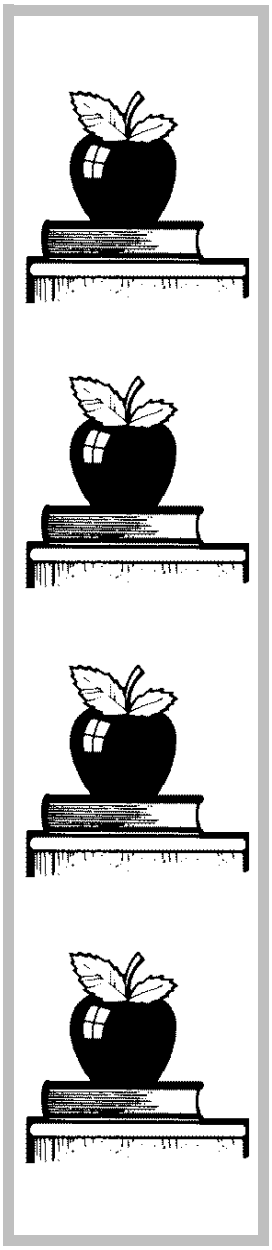


General Information for Providers

Medicaid and Other Medical Assistance Programs

MONTANA
Department of Public Health & Human Services

April 2005

This publication supersedes previous general information provider handbooks. Published by the Montana Department of Public Health & Human Services, February 2002.

Updated September 2002, October 2003, September 2004, November 2004, April 2005

MONTANA
Department of Public Health & Human Services

Table of Contents

Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Relations

Contact Provider Relations for questions about Medicaid, MHSP, and CHIP eyeglass and dental questions including payments, denials, eligibility, general claims questions, and PASSPORT or Medicaid questions or enrollment:

(800) 624-3958 In and out-of-state
(406) 442-1837 Helena
(406) 442-4402 Fax

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

PASSPORT Client Information

Clients who have general Medicaid questions may call the **Montana Medicaid Help Line** or write to:

(800) 362-8312 In and out-of-state

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

PASSPORT Program Officer

PASSPORT providers report errors, omissions, or discrepancies in enrollee utilization and cost reports to:

(406) 444-4540

PASSPORT Program Officer
DPHHS
Medicaid Services Bureau
P.O. Box 202951
Helena, MT 59620-2951

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Client Eligibility

There are several methods for verifying client eligibility; see *Client Eligibility and Responsibilities*, *Verifying Client Eligibility.*

Third Party Liability

For questions about private insurance, Medicare, or other third-party liability:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see *Program Policy Information* in the *Introduction* chapter.

Presumptive Eligibility

To verify Presumptive Eligibility call:

(800) 932-4453

To become a provider who can determine presumptive eligibility contact:

(406) 444-4540

Send written inquiries to:

Health Policy and Services Division
1400 Broadway
Helena, MT 59601

EDI Technical Help Desk

For questions regarding electronic claims submissions:

(800) 987-6719 In and out-of-state
(406) 442-1837 Helena
(850) 442-4402 Fax

Mail to:

ACS
ATTN: MT EDI
P.O. Box 4936
Helena, MT 59604

Administrative Reviews and Fair Hearings

To request an administrative review, address or direct the request to the division that issued the contested determination, and deliver or mail to:

DPHHS
111 N. Sanders
P.O. Box 4210
Helena, MT 59604-4210

To request a fair hearing, deliver or mail the request to the following address. A copy of the hearing request must also be delivered to the division that issued the contested determination.

DPHHS
Quality Assurance Division
Office of Fair Hearings
P.O. Box 202953
Helena, MT 59620-2953

Health Insurance Premium Payment Coverage

To apply for this program contact:

(800) 694-3084 In state
(406) 444-9440 Out of state and Helena

Send written inquiries to:

Health Insurance Payment Program
P.O. Box 202953
Helena, MT 59620-2953

Surveillance/Utilization Review

To report suspected fraud and abuse by providers:

(406) 444-4586
(800) 376-1115

To report suspected fraud and abuse by clients:

(406) 444-4167

Send written inquiries to:

Fraud and Abuse
Surveillance/Utilization Review
2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Nurse First

For questions regarding Nurse First Disease Management or the Nurse Advice Line, contact:

(406) 444-4540 Phone
(406) 444-1861 Fax

Nurse First Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Secretary of State

The Secretary of State's office publishes the most current version of the Administrative Rules of Montana (ARM):

(406) 444-2055 Phone

Secretary of State
P.O. Box 202801
Helena, MT 59620-2801

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information and a link to the Provider Information Website. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, DPHHS information, services available, and legal information.
Provider Information Website www.mtmedicaid.org or www.dphhs.mt.gov/hpsd/medicaid/medicaid2/index.htm	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • Medicaid Forms • PASSPORT To Health information • Team Care Information • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
CHIP Website www.chip.mt.gov	• Information on the Children's Health Insurance Plan (CHIP)
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides • FAQs • Related Links
Medicaid Mental Health and Mental Health Services Plan www.dphhs.mt.gov/about_us/divisions/addictive_mental_disorders/services/public_mental_health_services.htm	Mental Health Services information for Medicaid and MHSP

Introduction

Department of
Public Health and Human Services

JUDY MARTZ
GOVERNOR

GAIL GRAY, Ed. D.
DIRECTOR

STATE OF MONTANA

Dear Provider,

First and most important, let me say **thank you** for serving clients of Montana's medical assistance programs. The largest of these programs is Medicaid, which covers an average of 60,000 people a month. In almost all cases, these Montanans would be uninsured if not for Medicaid. Many clients work in jobs that do not offer health insurance. Others have serious health problems but are too young for Medicare or are in need of care (such as extended nursing facility care) that other insurers may not cover. Medicaid is especially important for children and pregnant women. Each month the program covers one in ten Montana children. Medicaid also pays for almost 40% of the births in Montana.

Over 11,000 providers are enrolled in Medicaid, including every Montana hospital and almost every physician. Nationwide, Medicaid represents about 10% of the revenue received by physicians and hospitals and over half of nursing facility revenue. In Montana, the program receives about 5 million claims a year and pays about $450 million a year to health care providers. Medicaid is administered by state government, with almost three-quarters of the funding coming from the federal government. Another $30 million a year is paid out through other medical assistance programs, such as the Children's Health Insurance Plan and the Mental Health Services Plan.

Our number one goal is to make sure the Department's clients have access to quality care, regardless of their medical condition or location. We also want to pay providers similar amounts for providing similar services, to reward economy and quality care, and to encourage clients to receive care within Montana whenever possible. For many types of care, our payment rates compare well with Medicaid programs across the U.S. and with the Medicare program in Montana.

I hope this manual gives you the information you need. We have tried to organize it well and present information clearly, so that your valuable time can be spent with clients and not on paperwork. By your willingness to be a provider for Montana's medical assistance programs, you serve your community every day. It is valuable work, and we want to help you succeed.

Sincerely,

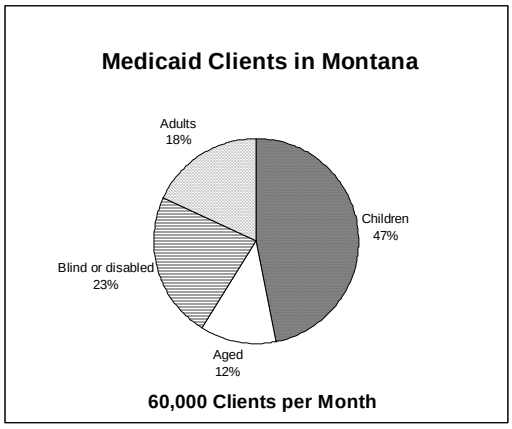
Gail Gray

Gail Gray

An Overview of the Montana Medicaid Program

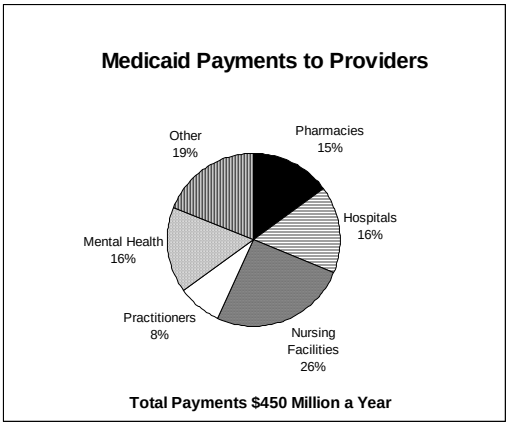
The Medicaid program plays an essential role in providing health insurance for Montanans. In our state, as in others, about 60% of the population obtains health insurance through employment, either their own or that of a family member. Employment-based insurance almost always comes with a substantial tax-free subsidy from employers. This route to coverage is not open, however, to many people who work in jobs that do not offer coverage, or who work part-time, or who do not work, possibly because of age or disability. Before the enactment of Medicare and Medicaid in 1965, health care for the elderly and the indigent was provided through a patchwork of programs sponsored by governments, charities and community hospitals. Many providers provided charity care or had uncollectable bills.

Today, Medicare provides insurance for essentially everyone aged 65 and over and for people with severe disabilities, regardless of income. It is a federal program serving 40 million people nationwide. Medicaid, meanwhile, is a series of programs administered by each state under broad federal guidelines. Medicaid serves 40 million people nationwide, including about 60,000 a month, or 7% of Montana's population.



In general, Medicaid provides three types of critical health protection for people with low incomes:

- Health insurance for families with children and for people with disabilities
- Long-term care, such as nursing facility care, for older people and people with disabilities (Medicare long-term care benefits are quite limited)
- Supplemental coverage for Medicare enrollees, including assistance paying Medicare premiums and obtaining services for which Medicare coverage is limited (such as prescription drugs)



Medicaid eligibility was traditionally linked to eligibility for specific income assistance programs, such as welfare and Supplemental Security Income. That link has weakened; still, adults who are below age 65, childless and not disabled rarely qualify for Medicaid, regardless of income.

In Montana, half of all Medicaid clients are under age 21, almost one quarter have disabilities, 12% are elderly and about 20% are adults who are neither

elderly nor disabled. Elderly and disabled clients tend to be much more costly than average because of the cost of nursing facility care in particular. Services for children and adults who are neither elderly nor disabled tend to be much less expensive than average.

Manual Organization

These manuals were designed to be an easy-to-use reference tool. A Table of Contents and an index allow you to quickly find answers to most questions. The margins contain important notes with extra space for writing notes. A list of *Key Contacts* is available at the beginning of each manual for quick reference.

The manuals include a *General Information For Providers* manual and a Medicaid billing manual for your provider type (e.g. *Prescription Drug Program*, *Durable Medical Equipment*, etc.). Each manual is divided into chapters, and each chapter contains sections. The *General Information For Providers* manual provides answers to general Medicaid questions about provider enrollment, client eligibility, and surveillance and utilization review. The Medicaid billing manual for your provider type contains specific program information including covered services, how to get prior authorization, and how to bill for specific services. This manual is designed to work with the Medicaid billing manual for your provider type. Each manual is complete with its own table of contents, appendix, definitions, commonly used acronyms, and an index. Many of the manuals have forms that can be copied.

Manual Maintenance

To have accurate, working manuals, they must be kept current. Changes and updates to manuals are provided through notices and replacement pages, which are posted on the Provider Information website (see *Key Contacts*). When replacing a page in a manual, file the old page in back of the manual for use with claims that originated under the old policy.

To avoid unnecessary denials and late payment, review all notices and install replacement pages immediately.

When downloading manual replacement pages, keep in mind that the pages are designed to print on the front and back of each sheet of paper. When a page has a change to it, the top of the page will show “Replacement Page” followed by the month and year the change was made.

Providers are responsible for knowing and following current laws and regulations. These manuals, replacement pages, and subsequent notices are provided only as a guide and do not create any contractual liability on the part of the Department to any provider.

Provider Training and Workshops

Medicaid offers a variety of seminars and workshops, which are announced in the monthly newsletter, the *Montana Medicaid Claim Jumper.* Training is also provided for new and established billing staff in your office or at our Helena office. To schedule a training session, call or write Provider Relations. (See *Key Contacts*.)

Getting Questions Answered

The provider manuals are designed to answer most questions; however, occasionally providers may need to contact a specific group (e.g., Provider Relations or a Prior Authorization Unit). The list of *Key Contacts* at the front of each manual has important phone numbers and addresses pertaining to that manual.

It is important for providers to read the monthly *Montana Medicaid Claim Jumper* newsletter. The newsletters covers most Medicaid program updates and changes and provides a listing of all new provider notices, manuals, and fee schedules. Provider notices, manuals, and fee schedules are not mailed to providers, but may be downloaded from the Provider Information website (see *Key Contacts*).

The following table is a list of contacts for policy information. *Appendix A* has a list of Medicaid covered services, and *Appendix B* has a list of *Local Offices of Public Assistance*. For questions on specific programs, see the Medicaid billing manual for your provider type. For eligibility questions, see *Client Eligibility and Responsibilities.*

Program Policy Information

Hours are 8:00 a.m. to 5:00 p.m. Monday - Friday

Contact	Information Available	Special Instructions
Department of Public Health and Human Services Health Resources Division P.O. Box 202951 1400 Broadway Helena, MT 59620-2951 (406) 444-4540 (Includes Children's Mental Health Services)	• Answers to policy questions • Timely filing appeals	• For claims information contact Provider Relations at (800) 624-3958 or (406) 442-1837. • For enrollment questions or changes contact Provider Relations at (800) 624-3958 or (406) 442-1837. • For client eligibility see the *Verifying Client Eligibility* table in the *Client Eligibility and Responsibilities* chapter. • For general Medicaid inquiries by clients, call the Montana Medicaid Help Line at (800) 362-8312. • For PASSPORT questions by providers call the Provider Help Line at (800) 624-3958 or (406) 442-1837 outside Montana.
Mental Health Services Bureau Addictive and Mental Disorders Division 555 Fuller Avenue P.O. Box 202905 Helena, MT 59620-2905 (406) 444-3964	Answers to mental health services policy questions	• For claims information contact Provider Relations at (800) 624-3958 or (406) 442-1837. • For enrollment questions or changes contact Provider Relations at (800) 624-3958 or (406) 442-1837. • For client eligibility see the *Verifying Client Eligibility* table in the *Client Eligibility and Responsibilities* chapter.
Chemical Dependency Bureau Addictive and Mental Disorders Division 555 Fuller Avenue P.O. Box 202905 Helena, MT 59629-2905 (406) 444-3964	Answers to chemical dependency services policy questions	• For Medicaid claims questions call (800) 624-3958 or (406) 442-1837. • For information on the Medicaid Chemical Dependency Program, call (406) 444-3964 • For Chemical Dependency Bureau - State Paid Substance Dependency/Abuse program information, provider enrollment, or prior-authorization and continued stay authorization, call (406) 444-3964. • For client eligibility see the *Verifying Client Eligibility* table in the *Client Eligibility and Responsibilities* chapter.
Senior and Long Term Care Division 111 Sanders, Room 210 P.O. Box 4210 Helena, MT 59604 (406) 444-4077	Answers to policy questions regarding: • Aging issues • Home and community based services • Nursing facility services	• For claims information contact Provider Relations at (800) 624-3958 or (406) 442-1837. • For enrollment questions or changes contact Provider Relations at (800) 624-3958 or (406) 442-1837. • For client eligibility see the *Verifying Client Eligibility* table in the *Client Eligibility and Responsibilities* chapter.
Children's Health Insurance Plan (CHIP) Department of Public Health and Human Services P.O. Box 202951 Helena, MT 59620-2951 (877) 543-7669	• Answers to policy questions • Answers to enrollment questions • Waiting list inquiries	• For information about becoming a Blue CHIP medical provider, contact BlueCross BlueShield at (406) 447-8787. • For medical claims information contact BlueCross BlueShield at (800) 447-7828 x8647 • For dental provider enrollment questions or changes contact Provider Relations at (800) 624-3958 or (406) 442-1837. • For dental and eyeglass claims information contact Provider Relations at (800) 624-3958 or (406) 442-1837.
Human & Community Services Division 1400 Broadway P.O. Box 202952 Helena, MT 59620-2952 (406) 444-1788	• Answers to Medicaid eligibility policy questions by providers or clients	• For information on covered services, see Appendix A, *Covered Services*, or refer to the specific provider manual.

Internet Information

A wealth of information is available on the internet through the Provider Information website

http://www.mtmedicaid.org

Providers can stay informed with the latest Medicaid news and upcoming events, download provider manuals, notices, manual replacement pages, fee schedules, newsletters, and forms. Many other items are available on the website such as Medicaid and PASSPORT enrollment forms, Medicaid definitions and acronyms, RA notices, frequently asked questions (FAQs), statistics, links to related websites, and much more. This website is updated almost daily, so visit us often!

Contract Services

Medicaid works with various contractors who represent Medicaid through the services they provide. Although it is not necessary for providers to know contractor duties, the following information on some major contractors is provided for your information.

Contractor	Service
ACS	• Processes Medicaid claims, MHSP claims, and CHIP dental and eyeglass claims • Enrolls providers in both Medicaid and PASSPORT To Health • Answers provider inquiries
Northrop Grumman	• Maintains The Economic Assistance Management System (TEAMS), the client eligibility system used by the local offices of public assistance • Maintains the Medicaid Eligibility and Payment System (MEPS)
MAXIMUS	• Enrolls clients in the PASSPORT To Health managed care program. • Answers general Medicaid questions for clients.
First Health	• Provides prior authorization, utilization review, and continued stay review for some mental health services
Mountain-Pacific Quality Health Foundation	• Provides prior authorization for many Medicaid services

Other Programs

In addition to Medicaid, the Department of Public Health and Human Services (DPHHS or the Department) sponsors the following programs for Montana residents:

Mental Health Services Plan (MHSP)

This plan is for individuals who are ineligible for Medicaid and whose family income is within program standard. The plan covers individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI). Many MHSP policies—for example, about provider enrollment and claims processing—are similar to those of Medicaid. Some differences exist, however. In this manual, see the sections in each chapter on *Other Programs*. See also the specific manual on Mental Health Services.

Children's Health Insurance Plan (CHIP)

CHIP offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured US citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program and purchases health insurance from BlueCross BlueShield (BCBS) of Montana. For eligibility and enrollment information, contact CHIP toll free at (877) 543-7669. For information about medical benefits, contact BCBS at (406) 447-8647 (in Helena) or toll free (800) 447-7828 x8647. CHIP dental and eyeglasses benefits are provided by DPHHS through the same contractor (ACS) that handles Medicaid provider relations and claims processing. This set of manuals applies to dental and eyeglass providers only. See the sections on *Other Programs* in each chapter.

Chemical Dependency Bureau State Paid Substance Dependency/Abuse Treatment Program

This plan is for individuals who are ineligible for Medicaid and whose family income is within program standard. This Department program is administered by the Chemical Dependency Bureau. The plan covers inpatient, outpatient, and day treatment for youth as well as outpatient services for adults who have a diagnosis of substance dependency. The services covered under this program are the same as the services covered under the Substance Dependency/Abuse Treatment Program for Medicaid clients. For more information call (406) 444-3964.

Children's Special Health Services (CSHS)

This program assists children with special health care needs who are not eligible for Medicaid by paying medical costs, finding resources, and conducting clinics. It is administered directly by DPHHS, and its policies are separate from those of Medicaid and CHIP. For more information call (406) 444-3622 or (800) 762-9891.

Other subsidized health insurance plans may be available from programs funded by the federal government or private organizations. For a listing, see the *Client Eligibility and Responsibilities* chapter.

MONTANA
Department of Public Health & Human Services

Provider Requirements

Provider Enrollment

To be eligible for enrollment, a provider must:

- Provide proof of licensure, certification, accreditation or registration according to Montana state laws and regulations.
- Provide a W-9.
- Meet the conditions in this chapter and in program instructions regulating the specific type of provider, program, and/or service.

Providers must complete a *Montana Medicaid Provider Enrollment Form*, which is a contract between the provider and the Department. Each provider is assigned a Montana Medicaid provider number, which should be used in all correspondence with Medicaid. Providers must apply for a Medicaid ID number for each type of service they provide. For example, a pharmacy that also sells durable medical equipment (DME) must apply for a Medicaid ID for the pharmacy and another ID for DME. To enroll as a Montana Medicaid provider, visit the Provider Information website or contact Provider Relations (see *Key Contacts*).

Medicaid payment is made only to enrolled providers.

Enrollment materials

Each newly enrolled provider is sent an enrollment letter with the new Medicaid provider number and instructions for obtaining additional information from the Provider Information website.

Most Medicaid-related forms are available in the provider manuals and on the Provider Information website. To order additional forms, complete and mail or fax the order sheet located in *Appendix C: Forms*. We do not provide CMS-1500, UB-92, or dental claim forms.

Medicaid renewal

For continued Medicaid participation, providers must maintain a valid license or certificate. For Montana providers, licensure or certification is automatically verified and enrollment renewed each year. If licensure or certification cannot be confirmed, the provider will be contacted. Out-of-state providers will be notified when Medicaid enrollment is about to expire. To renew enrollment, mail or fax a copy of your license or certificate to the Provider Relations Unit (see *Key Contacts*).

Out-of-state providers can avoid denials and late payments by renewing Medicaid enrollment early.

To avoid payment delays, notify Provider Enrollment of an address change in advance.

Changes in enrollment

Any changes in address, phone number, name, ownership, legal status, tax identification number, or licensure must be submitted in writing to the Provider Relations Unit (see *Key Contacts*). Faxes are not accepted because the provider's original signature and provider number are required. For change of address, you can use the form in *Appendix C: Forms*, and you must include a W-9 form. The Postal Service cannot forward government-issued warrants (checks).

Change of ownership

When ownership changes, the new owner must apply for a new Montana Medicaid number. For income tax reporting purposes, it is necessary to notify Provider Relations at least 30 days in advance about any changes that cause a change in your tax identification number. Early notification helps avoid payment delays and claim denials.

Electronic claims submission

Providers who submit claims electronically experience fewer errors and quicker payment. Providers who are using any of the following electronic claims submission methods must enroll with the ACS EDI Gateway clearinghouse (see *Key Contacts*). All Claims may be submitted electronically by the following methods:

- ***ACS field software WINASAP 2003.*** ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an X12N 837 transaction, but does not accept an X12N 835 transaction back from the Department.
- ***ACS clearinghouse.*** Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12N 837 format using a dial-up connection. Electronic submitters are required to certify their X12N 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the X12N 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- ***Clearinghouse.*** Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12 837 format. The provider's clearinghouse also needs to have their 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway

For more information on electronic claims submission, contact ACS EDI Gateway or Provider Relations (see *Key Contacts*).

Terminating Medicaid enrollment

Medicaid enrollment may be terminated at any time by writing to the Provider Relations Unit. Include your provider number and the termination date in the letter. The Department may also terminate your enrollment under the following circumstances:

- Breaches of the provider agreement
- Demonstrated inability to perform under the terms of the provider agreement
- Failure to abide by applicable Montana and U.S. laws
- Failure to abide by the regulations and policies of the U.S. Department of Health and Human Services or the Montana Medicaid program

Authorized Signature (ARM 37.85.406)

All correspondence and claim forms submitted to Medicaid must have a Medicaid provider number and an authorized signature. The signature may belong to the provider, billing clerk, or office personnel, and may be typed, stamped, computer generated or signed. When a signature is from someone other than the provider, that person must have written authority to bind and represent the provider for this purpose. Changes in enrollment information require the provider's original signature.

Provider Rights

- Providers have the right to end participation in Medicaid at any time.
- Providers may bill Medicaid clients for cost sharing (ARM 37.85.406)
- Providers may bill Medicaid clients for services not covered by Medicaid, as long as the provider and client have agreed in writing prior to providing services.
    - When the provider does not accept the client as a Medicaid client, it is sufficient for the provider to use a routine agreement to inform the client that he or she is not accepted as a Medicaid client, and that the client agrees to be financially responsible for the services received.
    - When the client has been accepted as a Medicaid client, but the services are not covered by Medicaid, the services can be billed to the client only after the provider has informed the client in writing (before providing the service) that those services are not covered by Medicaid, and the client has agreed to pay for the specific services on a private-pay basis. In this case, a routine agreement will not suffice. (ARM 37.85.406) For more information on billing Medicaid clients, see *Billing Procedures* in the specific provider manual.
- Providers have the right to choose Medicaid clients, subject to the conditions in *Accepting Medicaid clients* later in this chapter.

- Providers have the right to request administrative reviews and fair hearings for a Department action that adversely affects the provider's rights or the client's eligibility. (ARM 37.85.411)

Administrative Reviews and Fair Hearings (ARM 37.5.310)

If a provider believes the Department has made a decision that fails to comply with applicable laws, regulations, rules or policies, the provider may request an administrative review. To request an administrative review, state in writing the objections to the Department's decision and include substantiating documentation for consideration in the review. The request must be addressed to the division that issued the decision and delivered (or mailed) to the Department (see *Key Contacts* or the list of program policy contacts in the *Introduction* chapter of this manual). The Department must receive the request within 30 days from the date the Department's contested determination was mailed. Providers may request extensions in writing within this 30 days.

If the provider is not satisfied with the administrative review results, a fair hearing may be requested. Fair hearing requests must contain concise reasons the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules or policies. This document must be signed and received by the Fair Hearings Office (see *Key Contacts*) within 30 days from the date the Department mailed the administrative review determination. A copy must be delivered (or mailed) to the division that issued the determination within three working days of filing the request.

Provider Requirements

By signing the application to enroll in Montana Medicaid, providers agree to abide by the conditions of participation according to ARM 37.85.401. This section discusses some of those conditions; see the application for additional details and precise wording.

Accepting Medicaid clients (ARM 37.85.406)

Institutional providers, eyeglass providers, and non-emergency transportation providers may not limit the number of Medicaid clients they will serve. Institutional providers include nursing facilities, skilled care nursing facilities, intermediate care facilities for the mentally retarded, hospitals, institutions for mental disease, inpatient psychiatric hospitals, and residential treatment facilities.

Other providers may limit the number of Medicaid clients. They may also stop serving private-pay clients who become eligible for Medicaid. Any such decisions must follow these principles:

- No client should be abandoned in a way that would violate professional ethics.
- Clients may not be refused service because of race, color, national origin, age, or disability.
- Clients enrolled in Medicaid must be advised in advance if they are being accepted only on a private-pay basis.
- When a provider arranges ancillary services for their Medicaid client through other providers, such as a lab or a durable medical equipment provider, the ancillary providers are considered to have accepted the client as a Medicaid client and they may not bill the client directly. See ARM 37.85.406 (d) for details.
- Most providers may begin Medicaid coverage for retroactively eligible clients at the current date or from the date retroactive eligibility was effective (see *Client Eligibility and Responsibilities, Retroactive Eligibility* for details).
- When a provider bills Medicaid for services rendered to a client, the provider has accepted the client as a Medicaid client.
- Once a client has been accepted as a Medicaid client, the provider may not accept Medicaid payment for some covered services but refuse to accept Medicaid payment for other covered services.

Non-discrimination (ARM 37.85.402)

Providers may not discriminate in the provision of service to Medicaid clients or in employment of persons on the grounds of race, creed, religion, color, sex, national origin, political ideas, marital status, age, or disability. Providers shall comply with the Department of Health and Human Services regulations under Title VI and Title IX of the Civil Rights Act, Public Law 92-112 (Section 504 and 505) and the Montana Human Rights Act, Title 49, Chapter 2, MCA, and Americans with Disabilities Act as amended and all requirements imposed by or pursuant to the regulations.

Providers are entitled to Medicaid payment for diagnostic, therapeutic, rehabilitative or palliative services when the following conditions are met:

- Provider must be enrolled in Medicaid. (ARM 37.85.402)
- Services must be performed by practitioners licensed and operating within the scope of their practice as defined by law. (ARM 37.85.401)
- Client must be enrolled in Medicaid and non-restricted (see *Client Eligibility and Responsibilities* for restrictions). (ARM 37.85.415 and 37.85.205)
- Service must be medically necessary. (ARM 37.85.410) The Department may review medical necessity at any time before or after payment.

- Service must be covered by Medicaid and not be considered cosmetic, experimental or investigational. (ARM 37.82.102, 37.85.207, and 37.86.104)
- Medicaid and/or third party payers must be billed according to rules and instructions as described in the *Billing Procedures* chapter of each manual, the most current provider notices and manual replacement pages, and according to ARM 37.85.406 (Billing, reimbursement, claims processing and payment) and ARM 37.85.407 (Third Party Liability).
- Charges must be usual and customary. (ARM 37.85.212 and 37.85.406)
- Payment to providers from Medicaid and all other payers may not exceed the total Medicaid fee. For example, if payment to the provider from all responsible parties ($75.00) is greater than the Medicaid fee ($70.00), Medicaid will pay at $0. (ARM 37.85.406)
- Claims must meet timely filing requirements (see *Billing Procedures* in the specific provider manual for timely filing requirements). (ARM 37.85.406)
- Prior authorization requirements must be met. (ARM 37.85.406)
- PASSPORT approval requirements must be met. (ARM 37.86.5101 - 37.86.5112)

Medicaid payment is payment in full (ARM 37.85.406)

Providers must accept Medicaid payment as payment in full for any covered service, except applicable cost sharing that should be charged to the client.

Payment return (ARM 37.85.406)

If Medicaid pays a claim, and then discovers that the provider was not entitled to the payment for any reason, the provider must return the payment.

Disclosure

- Providers are required to fully disclose ownership and control information when requested by the Department. (ARM 37.85.402)
- Providers are required to make all medical records available to the Department. (ARM 37.85.410 and 37.85.414)

Client services

- All services must be made a part of the medical record. (ARM 37.85.414)
- Providers must treat Medicaid clients and private-pay clients equally in terms of scope, quality, duration, and method of delivery of services (unless specifically limited by regulations). (ARM 37.85.402)

- Providers may not deny services to a client because the client is unable to pay cost sharing fees. (ARM 37.85.402)

Confidentiality (ARM 37.85.414)

All Medicaid client and applicant information and related medical records are confidential. Providers are responsible for maintaining confidentiality of health care information subject to applicable laws.

Record keeping (ARM 37.85.414)

Providers must maintain all Medicaid-related medical and financial records for six years and three months following the date of service. The provider must furnish these records to the Department or its designee upon request. The Department or its designees may audit any Medicaid related records and services at any time. Such records may include (but are not limited to) the following:

- Original prescriptions
- Certification of medical necessity
- Treatment plans
- Medical records and service reports including (but not limited to):
- Patient's name and date of birth
- Date and time of service
- Name and title of person performing the service, if other than the billing practitioner
- Chief complaint or reason for each visit
- Pertinent medical history
- Pertinent findings on examination
- Medication, equipment, and/or supplies prescribed or provided
- Description and length of treatment
- Recommendations for additional treatments, procedures, or consultations
- X-rays, tests, and results
- Dental photographs/teeth models
- Plan of treatment and/or care, and outcome
- Specific claims and payments received for services
- Each medical record entry must be signed and dated by the person ordering or providing the service.
- Prior authorization information
- Claims, billings, and records of Medicaid payments and amounts received from other payers for services provided to Medicaid clients

Providers are responsible for keeping informed about applicable laws, regulations, and policies.

- Records and original invoices for items that are prescribed, ordered, or furnished
- Any other related medical or financial data

Compliance with applicable laws, regulations, and policies

All providers must follow all applicable rules of the Department and all applicable state and federal laws, regulations, and policies. Provider manuals are to assist providers in billing Medicaid; they do not contain all Medicaid rules and regulations. Rule citations in the text are a reference tool; they are not a summary of the entire rule. In the event that a manual conflicts with a rule, the rule prevails.

The following are references for some of the rules that apply to Montana Medicaid. The provider manual for each individual program contains rule references specific to that program.

- Title XIX Social Security Act 1901 et seq.
    - 42 U.S.C. 1396 et seq.
- Code of Federal Regulations (CFR)
    - CFR Title 42 - Public Health
- Montana Codes Annotated (MCA)
    - MCA Title 53 - Social Services and Institutions
- Administrative Rules of Montana (ARM)
    - ARM Title 37 - Public Health and Human Services

Links to rules are available on the Provider Information website (see *Key Contacts*). Paper copies of rules are available through Provider Relations and the Secretary of State's office (see *Key Contacts*).

Provider Sanctions (ARM 37.85.501 - 507 and 513)

The Department may withhold a provider's payment or suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid contract, federal and state laws, regulations and policies.

Other Programs

This is how the provider requirements apply in Department of Public Health and Human Services (DPHHS or the Department) programs other than Medicaid.

Mental Health Services Plan (MHSP)

To be paid by MHSP, the provider must be enrolled as a Medicaid provider and, in addition, must sign an addendum to the provider enrollment agreement that is specific to MHSP. If a signed addendum is not on file when a claim is submitted to MHSP, payment will be denied until the addendum is received.

Adults enrolled in MHSP can only receive MHSP services from a contracted Mental Health Center. Children may obtain MHSP services from other enrolled licensed practitioners.

All other policies and procedures in this chapter apply to MHSP providers in the same way they apply to Medicaid providers.

Mental health services **for Medicaid clients** are included within the scope of the Medicaid provider agreement and the separate addendum need not be signed.

Children's Health Insurance Plan (CHIP)

For CHIP, the policies and procedures in this chapter apply only to providers of dental services and eyeglasses. Provider Relations for providers of CHIP dental services and eyeglasses is handled by the same DPHHS contractor as for Medicaid. Providers of these services will receive CHIP provider numbers that differ from Medicaid provider numbers they may already have.

For all other services, CHIP provider relations is administered by BlueCross BlueShield of Montana; call (406) 447-8647 in Helena or (800) 447-7828 x8647 statewide.

Chemical Dependency Bureau State Paid Substance Dependency/Abuse Treatment Program

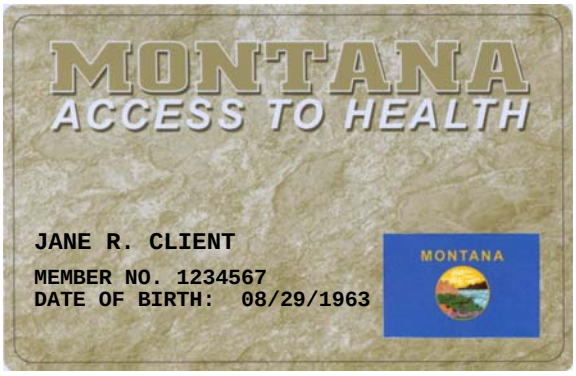
Providers of chemical dependency services must have a state-approved program, and the provider must sign a contract with the Department's Addictive and Mental Disorders Division for delivery of the covered services.

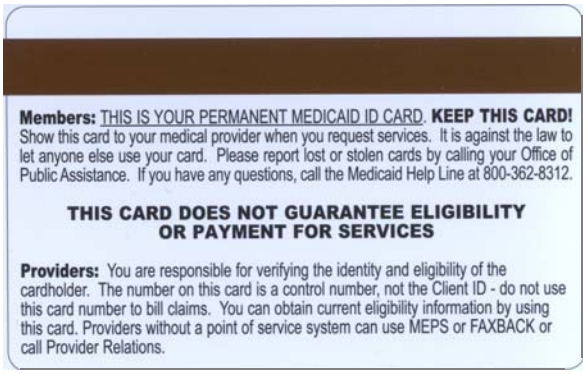
MONTANA
Department of Public Health & Human Services

Client Eligibility and Responsibilities

Medicaid ID Cards

Each Medicaid client is issued his or her own permanent *Montana Access To Health* Medicaid ID card (including QMB only clients). Clients must never throw away the *Montana Access To Health* card, even if their Medicaid eligibility ends. The ID card lists the client's name, date of birth, and a member number. The member number may be used for checking eligibility and for billing Medicaid. Since eligibility information is not on the card, it is necessary for providers to verify eligibility before providing services (see *Verifying Client Eligibility* in this chapter).





The *Montana Access To Health* card does not show client eligibility, so providers should verify eligibility before providing services.

Verifying Client Eligibility

Client eligibility may change monthly, so providers should verify eligibility each visit. Providers can check eligibility using any of the methods described in the following table.

Verifying Client Eligibility

Contact	Information Available	Special Instructions	Hours (Mountain Time)
Client Eligibility **Providers may use whichever method they find most convenient.**			
FAXBack (800) 714-0075	• Client eligibility • Third party liability • Managed care and other restrictions	• Call the number and enter your provider number, a client ID, and specific dates of service. • Before using FAXBack, have your fax number on file with Provider Relations. • When prompted, request the audit number or the transaction will not be completed.	24 hours a day/7 days a week
Automated Voice Response (800) 714-0060	• Client eligibility • Third party liability • Managed care and other restrictions • Amount of last check sent to provider	• Call the number and enter your provider number, a client identification number, and specific dates of service. • Verify eligibility for up to five clients in one call. • Program benefit limits not available here. Contact Provider Relations for limits (see *Key Contacts*).	24 hours a day/7 days a week
Medicaid Eligibility and Payment System (MEPS) meps.mtmedicaid.org or vhsp.dphhs.mt.gov	• Client eligibility • Managed care and service restrictions • Client demographics • Third party liability • Claim status history QMB only eligibility may not be available on MEPS	• From the pavilion, click on *Human Services* followed by *Medicaid.* • Before accessing MEPS, you must get a password by printing the MEPS Access Request form from the MEPS site and mailing to the address on the form. • If the client is not currently eligible, the following fields will not display on the Patient Information Screen: *PASSPORT Provider, Phone, HMO, Phone, Copay Met Date,* and *QMB.* • Only the first letter in each word is capitalized, causing some names to appear strange. For example, John Jones III would appear John Jones Iii.	24 hours a day/7 days a week
ACS EDI Gateway 2324 Killearn Center Blvd. Tallahassee, FL 32309 (800) 987-6719 Phone (850) 385-1705 Fax For ASC X12N 270/271 Eligibility transactions	• Client eligibility • Managed care and services restrictions • Client demographics • Third party liability	• Provider must enroll with EDI Gateway before they can receive X12N 270/271 eligibility transactions.	
Medifax EDI Medicaid Eligibility Verification System (MEVS) (800) 444-4336 ext. 2546 or 2072 www.medifax.com	• Client eligibility • Managed care and services restrictions • Client demographics • Third party liability	• MEVS vendors provide real time access for verifying patient eligibility for Montana Medicaid and other commercial payers. • MEVS vendors offer a variety of products to meet the needs of health care providers to include eligibility verification, claims credit card processing and statements.	24 hours a day/7 days a week
Provider Relations Department P.O. Box 8000 Helena, MT 59604 (406) 442-1837 (800) 624-3958 In state (406) 442-4402 fax	• Client eligibility • Prior authorization status • Claim status • Amount of last check sent to provider • Enrollment status • Service limits	Have your provider number and client ID number ready when you call.	8:00 a.m. to 5:00 p.m. Mon - Fri
Local Offices of Public Assistance	Client eligibility.	• See *Local Offices of Public Assistance* listing in *Appendix B.*	8:00 a.m. to 5:00 p.m. Mon - Fri
Presumptive Eligibility			
1-800-932-4453	Presumptive eligibility information	To become a provider who determines presumptive eligibility, call (406) 444-4540.	8:00 a.m. to 5:00 p.m. Mon - Fri

The following list shows some of the information returned to the provider in response to an eligibility inquiry:

- ***Client's Medicaid ID number***. This ID number is used when billing Medicaid and may be the client's social security number.
- ***Eligibility status***. Medicaid eligibility status for the requested date(s):
  - ***Full Medicaid***. When a client's eligibility denotes "Full" coverage, the client is eligible for all Medicaid covered services.
  - ***Basic Medicaid***. When eligibility denotes "Basic", the client is only eligible for some Medicaid services. For information on full and basic coverage, see *Appendix A: Medicaid Covered Services*.
  - ***QMB***. QMB means the client is a Qualified Medicare Beneficiary (see *When Clients Also Have Other Insurance*, within this chapter).
  - ***Team Care***. When eligibility denotes a "TC" indicatoror states "Team Care: Yes", the client is enrolled in the Team Care program. All services must be provided or approved by the designated PASSPORT provider.
- ***Designated provider***. The client's primary care provider's name and phone number are shown for clients who are enrolled in PASSPORT To Health or Team Care. In either case, all services must be provided or approved by the designated provider (see the *PASSPORT and Prior Authorization* chapter in this manual).
- ***TPL***. If the client has other insurance coverage (TPL), the name of the other insurance carrier is shown.
- ***Medicare ID number***. A Medicare ID number for clients who are eligible for both Medicaid and Medicare.

Client without card

Since eligibility information is not on the card, it is necessary for providers to verify eligibility before providing services (see *Verifying Client Eligibility* in this chapter), whether or not the clients presents a card. Confirm eligibility using one of the methods shown in the *Verifying Client Eligibility* table in this chapter. If eligibility is not available, the provider may contact the client's local office of public assistance (see *Appendix B*: *Local Offices of Public Assistance*).

Newborns

Care rendered to newborns can be billed under the newborn's original Medicaid ID number (assigned by the mother's local office of public assistance) until a permanent ID number (social security number) becomes available. The hospital or the parents may apply for the child's social security number. Parents are responsible for notifying their local office of public assistance when they have received the child's new social security number.

Inmates in Public Institutions (ARM 37.82.1321)

Medicaid does not cover clients who are inmates in a public institution.

Presumptive Eligibility for Pregnant Women

To encourage prenatal care, uninsured pregnant women may receive "presumptive eligibility" for Medicaid. If the client presents a *Presumptive Eligibility Notice of Decision,* call (800) 932-4453 to confirm presumptive eligibility. See *Appendix C: Forms* for a sample *Presumptive Eligibility Notice of Decision* (DPHHS HCS-428). Presumptive eligibility may be for only part of a month and does not cover inpatient hospital services, but does include all other applicable Medicaid services listed on the *Covered Services* table in *Appendix A.*

Designated providers determine presumptive eligibility and give the client a *Presumptive Eligibility Notice of Decision.* To be a designated provider, the provider must complete an application and provide one of the following services: outpatient hospital, rural health clinic, or clinic services under physician direction. To become a provider who determines presumptive eligibility, call (406) 444-4540.

Retroactive Eligibility

When a client is determined retroactively eligible for Medicaid, the client should give the provider a notice of retroactive eligibility (HCS-455). The provider has 12 months from the date retroactive eligibility was determined to bill for those services. When a client becomes retroactively eligible for Medicaid, the provider may:

- Accept the client as a Medicaid client from the current date.
- Accept the client as a Medicaid client from the date retroactive eligibility was effective.
- Require the client to continue as a private-pay client.

Institutional providers (nursing facilities, skilled care nursing facilities, intermediate care facilities for the mentally retarded, institutions for mental disease, inpatient psychiatric hospitals, and residential treatment facilities) must accept retroactively eligible clients from the date eligibility was effective.

Non-emergency transportation and eyeglass providers cannot accept retroactive eligibility.

For more information on billing Medicaid for retroactive eligibility services, see the *Billing Procedures* chapter in the Medicaid billing manual for your provider type.

Coverage for the Medically Needy

This coverage is for clients who have an income level that is higher than Medicaid program standards. However, when a client has high medical expenses relative to income, he or she can become eligible for Medicaid by "spending down" income to specified levels on a monthly basis. When the client chooses a "spend down" option, he or she is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Providers should verify if medically needy clients are covered by Medicaid on the date of service to determine whether to bill the client or Medicaid.

Because eligibility does not cover an entire month, the client's eligibility information may show eligibility for only part of the month, or the provider may receive a *Medicaid Incurment Notice*. The incurment notice, sent by the local office of public assistance, states the date eligibility began and the portion of the bill the client must pay. (See *Appendix C: Forms* for a sample *Medicaid Incurment Notice*.) If the provider has not received an incurment notice, he or she should verify eligibility for the date of service by any method described in this chapter or by contacting the client's local office of public assistance. Since this eligibility may be determined retroactively, the provider may receive the *Incurment Notice* weeks or months after services have been provided.

Clients also have a "cash option" where they can pay a monthly premium to Medicaid, instead of making payments to providers, and have Medicaid coverage for the entire month. This method results in quicker payment, simplifies the eligibility process, and eliminates incurment notices. Providers may encourage but not require clients to use the cash option.

Nurse First

Nurse First Programs provide disease management and nurse triage services for Medicaid clients throughout the state.

Nurse First Advice Line. The Nurse First advice line is a toll free, confidential phone line staffed by licensed-registered nurses available 24/7. Clients are encouraged to call the nurse line any time they are sick, hurt, or have a health concern. The nurses triage callers' symptoms using clinically based algorithms, then direct them to seek the appropriate level of services at the appropriate time. The nurses do not diagnose nor provide treatment. Most Medicaid clients are eligible to use the Nurse First Line, except clients in a nursing home/institution or clients with both Medicare Part A and B and Medicaid coverage. The program is voluntary through participation is strongly encouraged.

Nurse First Disease Management. Disease management services are available to selected Medicaid clients. The services promote adherence to providers' treatment plans and improve healthier living behaviors by providing individualized counseling and education through face-to-face and telephonic interaction with specially trained registered nurses. Medicaid clients identified with one of the following

conditions are eligible for participation: asthma, diabetes, heart failure, cancer and chronic pain. All clients meeting the eligibility requirements will automatically be enrolled in the program. Clients who do not wish to participate may "opt-out" or disenroll at any time. Program participation is strongly encouraged.

Montana Breast and Cervical Cancer Treatment Program

This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition. Clients enrolled in this program have "Basic" coverage (see Full and Basic Coverage earlier in this chapter). All other policies and procedures in this chapter apply. For information regarding screening through the MBCHP program, call (888) 803-9343.

When Clients Also Have Other Coverage

Clients with Medicare

Some Medicaid clients also are covered by Medicare, the federal program for people age 65 and over and for people with disabilities. These clients are often referred to as "dual eligibles." Medicare Part A covers inpatient hospital care, skilled nursing care facility and other services; Medicare Part B covers outpatient hospital care, physician care and other services. Most Medicare clients receive both Part A and Part B benefits. A few Medicare clients are eligible for one part only, so whether they are "dually eligible" depends on the service provided.

Medicare is the primary insurer for all dual eligibles. Medicaid may pay some or all of the client's Medicare premium, deductible and coinsurance costs, depending on the type of dual eligibility as follows. The following clients receive *Montana Access To Health* cards, so providers must check eligibility to determine the type of coverage the client has.

- **Qualified Medicare Beneficiaries (QMB)**
  For QMBs, Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles. See the *How Payment Is Calculated* in the Medicaid billing manual for your provider type to learn how these Medicaid payments are calculated. QMB clients may or may not also be eligible for Medicaid benefits.

  QMB Only. Medicaid will make payments only toward Medicare coinsurance and deductibles.

QMB/Medicaid. The list of covered services is the same as for other Medicaid clients. If a service is covered by Medicare but not by Medicaid, Medicaid will pay all or part of the Medicare deductible and coinsurance. If a service is covered by Medicaid but not by Medicare, then Medicaid will be the primary payer for that service.

- **Other Dual Eligibles**
  Coverage is the same as for QMB/Medicaid clients except that Medicaid does not pay the Medicare premiums.
- **Specified Low-Income Medicare Beneficiaries (SLMB)**
  For these clients, Medicaid pays the Medicare premium only. They do not receive Medicaid cards, are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Medicaid Benefits for Dually Eligible Clients

Type of Dual Eligible	Medicare Premium Paid By	Medicare Coinsurance & Deductible Paid By
QMB only	Medicaid	Medicaid*
QMB/Medicaid	Medicaid	Medicaid*
Other dual eligibles	Client	Medicaid*
Specified Low-Income Medicare Beneficiary	Medicaid	Client

* See the *How Payment Is Calculated* chapter in the specific provider manual to learn how Medicaid calculates payment for Medicare coinsurance and deductibles.

When clients have Medicare or other insurance, see *Coordination of Benefits* before billing Medicaid.

Clients with other sources of coverage

Medicaid clients may also have coverage through workers' compensation, employment-based coverage, individually purchased coverage, etc. Other parties also may be responsible for health care costs. Examples of these situations include communal living arrangements, child support, or auto accident insurance. These other sources of coverage have no effect on what services Medicaid covers. However, other coverage does affect the payment procedures; see *How Payment Is Calculated* in the Medicaid billing manual for your provider type.

The Health Insurance Premium Payment Program

Some Medicaid clients have access to private insurance coverage, typically through a job, but don't enroll because they cannot afford the premiums. In these cases, Medicaid **may** pay the premiums, at which time the private insurance plan becomes the primary insurer. The client also remains eligible for Medicaid. When Medicaid clients have access to private insurance coverage, they may apply for the Health Insurance Premium Payment Program. See *Key Contacts*.

Indian Health Service

The Indian Health Service (IHS) provides federal health services to American Indians and Alaska Natives. IHS is a secondary payer to Medicaid. For more information, see the table of *Subsidized Health Insurance Programs in Montana* at the end of this chapter.

Crime victims

The Crime Victims' Compensation Program is designed to help victims of crime heal. This program may provide funding for medical expenses, mental health counseling, lost wages support, funerals, and attorney fees. Crime Victim Compensation is a secondary payer to Medicaid. For more information see table of *Subsidized Health Insurance Programs in Montana* at the end of this chapter.

When Clients are Uninsured

Several state and federal programs are available to help the uninsured; see *Subsidized Health Insurance Programs in Montana* at the end of this chapter.

Client Responsibilities

Medicaid clients are required to:

- Notify providers that they have Medicaid coverage.
- Present a valid Montana Access To Health card at each visit.
- Pay Medicaid cost sharing amounts; see *Billing Procedures* chapter in provider-specific manual.
- Notify providers of any other coverage, such as Medicare or private insurance.
- Notify providers of any change in coverage.
- Forward any money received from other insurance payers to the provider.
- Inform their local office of public assistance about any changes in address, income, etc.

Medicaid clients may see any Medicaid-enrolled provider as long as PASSPORT To Health and prior authorization guidelines are followed, and as long as they are not enrolled in Team Care.

Other Programs

Here is how client eligibility provisions apply in Department of Public Health and Human Services programs other than Medicaid.

Mental Health Services Plan (MHSP)

MHSP clients will present a hard white plastic card. Their MHSP card makes them eligible only for those services covered by MHSP, which are described in the *Mental Health Services* and *Prescription Drug Program* manuals. Medicaid clients do not need an MHSP card to receive mental health services.

Children's Health Insurance Plan (CHIP)

Few children are eligible for both Medicaid and CHIP simultaneously. If a patient presents both cards, check the dates of Medicaid eligibility and the child's CHIP enrollment. If both cards are valid, treat the patient as a CHIP patient. Services not covered by CHIP may be covered by Medicaid.

If a client presents a CHIP card for dental services, then see the CHIP Dental Services manual for information about coverage and billing. If a client presents a CHIP card for eyeglasses, the card is valid only with the CHIP program's designated supplier (see the *CHIP* section of the *Optometric and Eyeglass Services* manual). If a client presents a CHIP card for any other service, see the CHIP provider manual published by BlueCross BlueShield of Montana. Call (406) 447-8647 in Helena or (800) 447-7828 x8647 statewide for more information.

Chemical Dependency Bureau State Paid Substance Dependency/Abuse Treatment Program (CDB-SPSDATP)

Clients in this program are not issued a Montana Access To Health card. Clients should apply for services directly from the state approved programs. For a list of these programs call (406) 444-9408. Services require prior authorization and authorization for continued stay review.

Subsidized Health Insurance Programs in Montana
(Providers May Refer Clients to the Following Programs)

Program	Administered By	Target Populations	For More Information on Eligibility
Medicaid	Montana Dept. of Public Health and Human Services	Low-income children and their family members, and disabled individuals.	Local Office of Public Assistance
Children's Health Insurance Plan (CHIP)	Montana Dept. of Public Health and Human Services	Low-income, uninsured children who are ineligible for Medicaid.	1-877-KIDS-NOW (1-877-543-7669) www.chip.mt.gov
Caring Program for Children	BlueCross BlueShield of Montana	Low-income children who are ineligible for Medicaid.	(800) 447-7828 X3612
Montana Youth Care	BlueCross BlueShield of Montana	Low-income children who are ineligible for CHIP, Caring Program, and Medicaid.	(800) 447-7828 X8295
Montana Comprehensive Health Association	BlueCross BlueShield of Montana	People who have trouble buying health insurance because of their health condition.	(800) 447-7828 X8537
Children's Special Health Services	Montana Dept. of Public Health and Human Services	Children with special health care needs.	(800) 762-9891 or (406) 444-3622
Mental Health Services Plan	Montana Dept. of Public Health and Human Services	Individuals with a qualifying mental health diagnosis who are ineligible for Medicaid.	Community Mental Health Center
Medicare	Centers for Medicare and Medicaid Services (formerly U.S. Health Care Financing Administration)	People who are age 65 and over, have a disability, or have end-stage renal disease.	U.S. Social Security Administration office or www.medicare.gov
Indian Health Service	Billings Area Indian Health Services	All enrolled members of federally recognized tribes.	(406) 247-7107 or www.ihs.gov
Crime Victims' Compensation Program	Montana Dept. of Justice	Crime victims and their dependents and relatives.	(406) 444-3653 www.usdoj.gov/crimevictims.htm
Workers' Compensation	State Fund and independent workers' compensation insurers	People with injuries or illnesses related to their work.	Workers may call (406) 444-6543

Note: Eligibility rules are complex; clients and providers should check with the program administrator for specifics.

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PASSPORT and Prior Authorization

What Is PASSPORT To Health, Team Care, and Prior Authorization? (ARM 37.85.205 and 37.86.5101 - 5120)

PASSPORT To Health, Team Care, Nurse First and Prior Authorization are examples of the Department's efforts to ensure the appropriate use of Medicaid services. Each of these programs has specific requirements.

Medicaid does not pay for services when prior authorization, PASSPORT, or Team Care requirements are not met.

PASSPORT To Health

PASSPORT To Health Managed Care Program is Montana Medicaid's Primary Care Case Management (PCCM) Program. Under PASSPORT, Medicaid clients choose one primary care provider and develop an ongoing relationship that provides a "medical home." With some exceptions, all services to PASSPORT clients must be provided or approved by the PASSPORT provider.

The PASSPORT mission is to manage the delivery of health care to Montana Medicaid clients in order to improve or maintain access and quality while minimizing use of health care resources. Approximately 68% of the Medicaid population is enrolled in PASSPORT. Most Montana Medicaid clients must participate in PASSPORT. The PASSPORT Program saves the Medicaid Program approximately $20 million each year. These savings allow improved benefits and/or reimbursement elsewhere in the Medicaid Program.

Team Care

Team care is a utilization control and management program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT primary care provider (PCP), one pharmacy, Nurse First, and Montana Medicaid. This group works together to help clients decide how, when and where to access services. Clients with a history of using services at an amount or frequency that is not medically necessary are enrolled in Team Care. These clients must enroll in PASSPORT, select a PASSPORT PCP and single pharmacy, and call the Nurse First Advice Line prior to accessing Medicaid health services (except for emergency services). These clients receive extensive outreach and education from Nurse First nurses and are instructed on the proper use of the Montana Medicaid healthcare system.

Clients are identified for the Team Care Program by claims data analysis, recommendation from the Drug Utilization Review Board or by provider referral. Providers who want to recommend a client to the Team Care program should submit a completed *Team Care Provider Referral Fax Form* available on the Provider Information website or contact the Team Care program officer (see *Key Contacts*).

Team Care is a component of the PASSPORT To Health program, and all PASSPORT rules and guidelines apply to Team Care clients. For more information on the Team Care Program, visit the *Team Care* page on the Provider Information website (see *Key Contacts*) or see the Medicaid manual for your provider type. For more information on the Nurse First Program, see *Nurse First* in the *Client Eligibility and Responsibilities* chapter of this manual.

Prior authorization

When both PASSPORT approval and prior authorization are required, they must be recorded in different fields on the claim form.

Prior authorization (PA) refers to a list of services that require Department authorization before they are performed. Some services may require both PASSPORT approval and prior authorization. If a service requires prior authorization, the requirement exists for all Medicaid clients. Prior authorization is usually obtained through the Department or a prior authorization contractor. If both PASSPORT approval and prior authorization are required for a service, then both numbers must be recorded in different fields on the Medicaid claim form (see the *Completing a Claim* chapter in the Medicaid billing manual for your provider type). Most Montana Medicaid fee schedules indicate when PA is required for a service. For more information on prior authorization, see the *PASSPORT and Prior Authorization* chapter in the Medicaid billing manual for your provider type.

In practice, providers will most often encounter clients who are enrolled in PASSPORT. Whether the client is enrolled in PASSPORT or Team Care, the eligibility information denotes the client's primary care provider. Services are only covered when they are provided or approved by the designated PASSPORT provider or Team Care pharmacy shown in the eligibility information. Specific services may require both prior authorization and PASSPORT provider approval. To be covered by Medicaid, all services must also be provided in accordance with the requirements listed in the *Provider Requirements* chapter of this manual and in the Medicaid billing manual for your provider type.

Verifying PASSPORT Enrollment

Client eligibility verification will denote whether the client is enrolled in PASSPORT. The client's PASSPORT provider and phone number are also available, and the client may have Full or Basic coverage. Instructions for checking client eligibility are in the *Client Eligibility and Responsibilities* chapter of this manual.

PASSPORT and Emergency Services

PASSPORT provider approval is not required for emergency services. Emergency medical services are those services required to treat and stabilize an emergency medical condition. Non-emergencies in the ED will not be reimbursed, except for the screening and evaluation fee and any appropriate imaging and diagnostic services that are part of the screening. For more information, see *Emergency Services* on the Provider Information website or in the Medicaid billing manual for your provider type (see *Key Contacts*).

If inpatient hospitalization is recommended as post stabilization treatment, the hospital must get a referral from the client's PASSPORT provider. If the hospital attempts to contact the PASSPORT provider and does not receive a response within 60 minutes, authorization is assumed. To be paid for these services, send the program officer (see *Key Contacts*) documentation that clearly shows the time of the attempt to reach the PASSPORT provider and the time of the initiation of post stabilization treatment. There must be a 60 minute time lapse between these two events.

PASSPORT Referral and Approval

If a Medicaid client is seeking a medically necessary service that the PASSPORT provider does not provide, and the service requires PASSPORT approval, then the PASSPORT provider refers the client to another provider. Referrals can be made to any other provider who accepts Montana Medicaid. Referrals from the PASSPORT provider may be verbal or in writing and must be documented by the PASSPORT provider. Referrals must also be accompanied by the primary care provider's PASSPORT number for use on the claim. See Appendix A for a Medicaid covered services and PASSPORT referral information. Providers should refer to their Medicaid billing manual for their provider type.

PASSPORT and Indian Health Services

Clients who are eligible for both Indian Health Services (IHS) and Medicaid may choose a PASSPORT-enrolled IHS provider or another provider as their PASSPORT provider. Clients who are eligible for IHS do not need a referral from their PASSPORT provider to obtain services from IHS. However, if IHS refers the client to a non-IHS provider, the PASSPORT provider must approve the referral.

Non-PASSPORT Provider and a PASSPORT Client

To be covered by Medicaid, all services must be provided in accordance with the requirements listed in the *Provider Requirements* chapter of this manual and in the *Covered Services* chapter of the Medicaid billing manual for your provider type. Prior authorization and Team Care requirements must also be followed.

- If a client is enrolled in PASSPORT, the services must be provided or approved by the client's PASSPORT provider. Some services do not

require PASSPORT approval (See *Appendix A Medicaid Covered Services*).

- The PASSPORT provider's approval may be verbal or written but should be documented and maintained in the client's file, and the claim form must contain the PASSPORT provider's PASSPORT number. The referral must be documented in the PCP's client file or telephone log. Documentation should not be submitted with the claim.
- The client's PASSPORT provider must be contacted for approval for each visit.
- Using another provider's PASSPORT number without approval is considered fraud.
- If a PASSPORT provider refers a client to you, do not refer that client to someone else without the PASSPORT provider's approval. This is considered piggy backing and Medicaid will not cover the service.
- A facility or non-PASSPORT provider is not authorized to pass on a PASSPORT approval number. This may be considered fraud.
- To verify client eligibility, see the *Client Eligibility* chapter in the *General Information For Providers* manual.

How to Become a PASSPORT Provider

Any provider who has primary care within his or her scope of practice and is practicing primary care can be a PASSPORT provider. PASSPORT providers receive a monthly case management fee of $3.00 for each enrolled PASSPORT client. Providers who wish to become a PASSPORT provider must:

- Enroll in Medicaid. Medicaid enrollment forms are available on the *Provider Information* website, or providers may call Provider Relations (see *Key Contacts*).
- Enroll in PASSPORT. The PASSPORT agreement is available on the Provider Information website, or providers may call Provider Relations (see *Key Contacts*).

PASSPORT Tips

- Verify the client's Medicaid eligibility by using one of the methods described in the *Client Eligibility and Responsibilities* chapter of this manual.
- Do not bill for case management fees; they are paid automatically to the provider each month.
- If you are not your client's PASSPORT provider, and the services require PASSPORT provider approval, contact the client's PASSPORT provider for approval. If the service is approved, include the PASSPORT approval number on the claim, or it will be denied.

- The same cost sharing, service limits, and provider payment rules apply to PASSPORT and non-PASSPORT clients and services.
- For claims questions, refer to the *Billing Procedures* chapter of the Medicaid billing manual for your provider type, or call Provider Relations (see *Key Contacts*).

Getting Questions Answered

The *Key Contacts* section in the front of this manual provides important phone numbers and addresses. Providers may call Provider Relations for answers to questions about Medicaid or PASSPORT enrollment, claims, client eligibility, and more. Clients may call the Montana Medicaid Help Line for answers to most Medicaid and PASSPORT questions. Provider newsletters keep providers updated on Medicaid and PASSPORT changes and are available on the *Provider Information* web site (see *Key Contacts*).

MONTANA
Department of Public Health & Human Services

Surveillance/Utilization Review

Surveillance/Utilization Review (42 CFR 456)

The Department's Surveillance/Utilization Review Section (SURS) carries out a federally mandated program that performs retrospective reviews of paid claims. SURS is required to safeguard against unnecessary and inappropriate use of Medicaid services and against excess payments. If the Department pays a claim and later discovers that the service was incorrectly billed or the claim was erroneously paid in some other way, the Department is required by federal regulation to recover any overpayment. Referrals are received from:

- Providers
- Clients
- Department program officers
- Other agencies such as Medicare, other states' Medicaid programs, etc.
- Legislators
- Private citizens
- OmniAlert (A fraud detection tool which performs statistical analysis on paid claims data to detect abnormal patterns)

After the provider is notified of an audit, SURS personnel send a spreadsheet to the provider with paid claims data. The provider is requested to send supporting documentation for the items listed on the spreadsheet. The Department allows adequate time for the data collection and submission to the Department. A SURS compliance specialist completes the audit, and if the calculated overpayment exceeds $5000, the case is presented to the administrators, bureau chiefs, program officers, legal representatives, the SURS supervisor and an agent from the Department of Justice. The case is reviewed in its entirety, and if the committee agrees, a "overpayment letter" will be sent. If the amount of calculated overpayment is less than $5000, the case is reviewed by the bureau chief, program officer and the SURS supervisor. Their approval will initiate an overpayment letter.

The overpayment letter specifies the amount of the overpayment, the date the funds are due, interest payments, appeal rights information, details on how to proceed, and the appropriate contact person.

If a provider is billing incorrectly but does not have an overpayment greater than $100, SURS may send the provider an educational letter. This letter would describe the problem areas and suggest resources and materials to assist the provider in correcting the problem. The provider's claims are reviewed at a later date to verify that the billing problem has been corrected.

Key Points

- The SURS unit encourages providers to call with any questions or concerns regarding the audit of paid claims. (See *Key Contacts.*)
- The SURS unit or Provider Relations cannot suggest specific codes to be used in billing for services.
- Medicaid is entitled to recover payment made to providers when a claim was paid incorrectly for any reason. (ARM 37.85.406)
- Medicaid pays for only those prescriptions and services that are covered by Medicaid.
- Medicaid may go back six years and three months when conducting an audit.
- Medicaid may charge interest on recovered funds.
- Medicaid may withhold payment or suspend or terminate Medicaid enrollment if the provider has failed to abide by terms of the Medicaid contract, federal and state laws, regulations and policies. (ARM 37.85.501, 37.85.502, and 37.85.513)
- Prior authorization does not guarantee payment; a claim may be denied or money paid to providers may be recovered if the claim is found to be inappropriate.

Billing Tips

The best way to avoid an audit is to make sure all claims are billed accurately. The following suggestions may help reduce billing errors:

1. Be familiar with the **current** Medicaid provider manuals and fee schedules, and provider notices. These are available on the Provider Information website or by contacting Provider Relations (see *Key Contacts*)

2. Use current CPT-4, HCPCS, and ICD-9-CM coding books, and refer to the long descriptions. Relying on short descriptions can result in inappropriate billing.

3. Maintain complete records. (See *Provider Requirements, Record Keeping.*)

4. Attend classes on coding offered by certified coding specialists.

5. Utilize services and training offered by the Medicaid Provider Relations field representative. (See *Introduction, Provider Training and Workshops.*)

6. Avoid billing for the same service/supply twice. Contact Provider Relations for the status of submitted claims. (See *Key Contacts*.)

7. Use specific codes rather than miscellaneous codes. For example, 99213 is more specific (problem-focused visit) than 99499 (unlisted evaluation and management service).

8. Bill only for those items/services covered by Medicaid. (See current fee schedule and provider manuals.)

9. Bill only under your own provider number.

10. Bill only for services you provided.

11. Bill for the appropriate level of service provided. For example, the CPT-4 coding book contains detailed descriptions and examples of what differentiates a level 1 office visit (99201) from a level 5 office visit (99205).

12. Services covered within "global periods" for certain CPT-4 procedures are not paid separately and should not be billed separately. Most surgical and obstetric procedures and some medical procedures include routine care before and after the procedure. Medicaid fee schedules show the global period for each CPT-4 service.

13. Pay close attention to modifiers used with CPT-4 and HCPCS codes on both CMS-1500 bills and UB-92 bills. Modifiers are becoming more prevalent in health care billing, and they often affect payment calculations.

14. Choose the least costly alternative. For example, if a client is able to operate a standard wheelchair then a motorized wheelchair should not be prescribed or provided.

15. For repeat clients, use an established patient code (e.g. 99213) instead of a first time patient code (e.g. 99203). A first time patient code may be used when:
    - The provider sees the client for the first time.
    - It has been at least three years since the client has seen the provider or another provider of the same specialty who belongs to the same group practice.

16. Use the correct "units" measurement on CMS-1500 and UB-92 bills. In general, Medicaid follows the definitions in the CPT-4 and HCPCS billing manuals. Unless otherwise specified, one unit equals one visit or one procedure.

For specific codes, however, one unit may be 15 minutes, a percentage of body surface area, or another quantity. Always check the long text of the code description.

17. Physical therapists may bill for restorative services, not maintenance (except under Home and Community Based Services waiver).

18. Professional interpretation of x-rays and other diagnostic tests can only be billed once - typically by the radiologist.

19. Durable Medical Equipment, Orthotics, Prosthetics and Supplies (DMEOPS) must be medically necessary and prescribed in writing prior to delivery by a physician or other licensed practitioner of the healing arts within the scope of his or her practice as defined by state law. (ARM 37.86.1802)

20. Prescriptions for medical supplies used on a continuous basis shall be renewed by a physician at least every 12 months and must specify the monthly quantity of the supply.

21. When billing for DMEOPS, a completed Certificate of Medical Need (CMN) for each item (when required) must be maintained in the provider's files in accordance with the requirements of ARM 37.85.414 (see *Provider Requirements*, *Record Keeping*).

22. Observe rental time restrictions on durable medical equipment. Medicaid will recover rental payments made past the purchase price. Rental fees include supplies, maintenance, and repairs, so do not bill for these items.

23. When requesting advice or direction from a Department program officer, it is wise to ask for it in writing for your records.

Other Programs

The SURS audit process is the same for Medicaid and the Mental Health Services Plan. The Children's Health Insurance Plan and the Chemical Dependency Bureau State Paid Substance Dependency/Abuses Treatment Program have separate programs for reviewing paid claims.

Appendix A: Medicaid Covered Services

- This table contains general information about services by provider type. It is not a comprehensive list of services or prior authorization and PASSPORT requirements. For detailed information regarding prior authorization, PASSPORT approval, coverage, and cost sharing information, refer to the Medicaid billing manual for your provider type (e.g., *Physician Related Services*, *Hospital Outpatient Services*, etc.). Providers may verify PASSPORT and prior authorization requirements for specific services by contacting Provider Relations (see *Key Contacts*).
- Covered services are subject to change based on changes in funding, legislative action, and changes in administrative rules.
- When a client is enrolled in PASSPORT To Health, most services must be provided or approved by the PASSPORT provider. The following table shows whether clients need PASSPORT provider approval to visit a provider. Even though clients don't need PASSPORT approval to visit some providers, some of the services rendered by these providers may require PASSPORT approval.

Medicaid Covered Services

Services Provided by:	Covered Under Full Medicaid?	Covered Under Basic Medicaid?	Need PASSPORT Provider Approval?	Need Prior Authorization?	Age Restrictions
Ambulances	Yes	Yes	No	Yes for scheduled transport (For emergencies, providers have 60 days following service to obtain authorization.)	No
Ambulatory surgical centers	Yes	Yes	Yes *** Except for some services listed at the end of this table.	Some services require PA.	Some procedures and diagnosis codes have age restrictions.
Audiologists	Yes	No*	No	No	No
Chiropractors	Yes (Under 21 and QMB only)	Yes (Under 21 and QMB only)	Yes	No	Under 21 and QMB only

Medicaid Covered Services (continued)

Services Provided by:	Covered Under Full Medicaid?	Covered Under Basic Medicaid?	Need PASSPORT Provider Approval?	Need Prior Authorization?	Age Restrictions
Dentists and Orthodontists	Yes	No*	No Some services require authorization, such as dental surgery.	Some services require PA or have limits.	Some procedures and diagnosis codes have age restrictions.
Denturists	Yes	No*	No	Some services require PA or have limits.	Some procedures and diagnosis codes have age restrictions.
Dialysis – attendant in the home	Yes	Yes	No	Yes	No
Dialysis – freestanding centers	Yes	Yes	No	No	No
Durable medical equipment, medical supplies, and prosthetics providers	Yes	No* Except for items identified in the program's fee schedule.	No	Some services require PA.	Some age restrictions apply. See the Medicaid billing manual for your provider type.
Eyeglass providers	Yes (Some limitations apply.)	No*	No	No	No
Federally qualified health centers (FQHC)	Yes	Yes (Except for dental services.)	Yes *** Except for some services listed at the end of this table.	No	No
Hearing aid providers	Yes	No*	No	Yes	No
Home and community based service providers (HCBS waiver) provided to qualifying clients in the client's home	Yes, but must be screened and meet level of care requirements.	Yes, but must be screened and meet level of care requirements.	No	Yes	No
Home health care providers	Yes	Yes	Yes	Yes	No

Medicaid Covered Services (continued)

Services Provided by:	Covered Under Full Medicaid?	Covered Under Basic Medicaid?	Need PASSPORT Provider Approval?	Need Prior Authorization?	Age Restrictions
Home infusion therapy providers	Yes	No	No	Some services require PA.	No
Hospice providers	Yes	Yes	No	No	No
Hospitals (inpatient)	Yes	Yes	Yes *** Except for some services listed at the end of this table.	Some in-state services require PA. All out-of state admissions and some services require PA.	No
Hospitals (outpatient)	Yes	Yes	Yes *** Except for some services listed at the end of this table.	No Except for therapy services over 40 hours for children	No
Hospitals (emergency services)	Yes	Yes	No	No	No
Hospitals (swing bed)	Yes	Yes	No	Some services require PA.	No
Indian Health Services (IHS)	Yes	Yes	No	Some services require PA.	
Intermediate care facilities for the mentally retarded	Yes	Yes	No	Some services require PA.	No
Laboratory providers	Yes	Yes	No	No	No
Licensed clinical professional counselors	Yes	Yes	No	Some services require PA.	No
Mental health case management providers	Yes	Yes	No	Some services require PA.	No
Mental health centers	Yes	Yes	No	Some services require PA.	No
Mid-level practitioners (includes advanced practice nurses and physician assistants)	Yes	Yes	Yes *** Except for some services listed at the end of this table.	Some services require PA.	Some procedures and diagnosis codes have age restrictions.

Medicaid Covered Services (continued)

Services Provided by:	Covered Under Full Medicaid?	Covered Under Basic Medicaid?	Need PASSPORT Provider Approval?	Need Prior Authorization?	Age Restrictions
Nursing facilities	Yes	Yes	No	Some services require PA.	No
Nursing facilities for the aged mentally retarded	Yes	Yes	No	Some services require PA.	No
Nutritionists	Yes	N/A	Yes	No	Under 21 only**
Occupational therapists	Yes	Yes	Yes	No	No
Optometrists and Ophthalmologists (medical treatment of eye disease)	Yes Some limitations apply.	No*	No	No	No
Personal care services in a client's home	Yes	No	No	Yes	No
Pharmacies	Yes	Yes	No	Some services require PA.	No
Physical therapists	Yes	Yes	Yes	No	No
Physicians	Yes	Yes	Yes *** Except for some services listed at the end of this table.	Some services require PA.	Some procedures and diagnosis codes have age restrictions.
Podiatrists	Yes	Yes	No	No	No
Private duty nursing providers in non-institutional settings	Yes	N/A	Yes	Yes	Under 21 only**
Psychiatrists	Yes	Yes	No	No	Some procedures and diagnosis codes have age restrictions.
Psychologists	Yes	Yes	No	Some services require PA.	No

Medicaid Covered Services (continued)

Services Provided by:	Covered Under Full Medicaid?	Covered Under Basic Medicaid?	Need PASSPORT Provider Approval?	Need Prior Authorization?	Age Restrictions
Public health clinics	Yes	Yes	Yes *** Except for some services listed at the end of this table.	Some services may require PA.	Some procedures and diagnosis codes have age restrictions.
Residential treatment centers	Yes	N/A	No	Yes	Under 21 only
Respiratory therapy providers	Yes	N/A	Yes	No	Under 21 only**
Rural health clinics (RHC)	Yes	Yes	Yes *** Except for some services listed at the end of this table.	No	No
School based services providers	Yes	N/A	Yes Except immunizations and mental health services.	No Except private duty nursing services.	Under 21 only
Speech therapists	Yes	Yes	Yes	No	No
Social workers (licensed)	Yes	Yes	No	Some services require PA.	No
Substance Dependency, inpatient and day treatment providers (state approved programs)	Yes	N/A	No	Yes	Under 21 only
Substance Dependency, outpatient providers (state approved programs)	Yes	Yes	No	No	No
Targeted case management providers	Yes	Yes	No	No	Some procedures and diagnosis codes have different age restrictions.

Medicaid Covered Services (continued)

Services Provided by:	Covered Under Full Medicaid?	Covered Under Basic Medicaid?	Need PASSPORT Provider Approval?	Need Prior Authorization?	Age Restrictions
Therapeutic family care	Yes	N/A	No	Yes	Under 21 only
Therapeutic group home care	Yes	N/A	No	Yes	Under 21 only
Transportation (commercial)	Yes	Yes	No	Yes (Call 1-800-292-7114 for PA)	No
Transportation (specialized non-emergency)	Yes	Yes	No	Yes (Call 1-800-292-7114 for PA)	No
X-ray providers	Yes	Yes	No Some services may require authorization.	No	No

* This service may be covered if it is "essential for employment" or an emergency. See the Medicaid billing manual for your provider type for details.

** This service is covered for all ages under the Home and Community Based Services program.

*** These services do not require PASSPORT approval:

- Pregnancy related services
- Immunizations
- Anesthesiology services
- Pathology services
- Testing and treatment for sexually transmitted diseases
- Family planning services
- Mental health services
- Ophthalmology services
- Testing for blood lead levels

Appendix B: Local Offices of Public Assistance

Local Offices of Public Assistance			
County	**Address**	**Phone Number**	**Fax Number**
1. Beaverhead	2 South Pacific #9 Dillon, MT 59725	683-3773	683-5080
2. Big Horn	23 West 8th P.O. Box 426 Hardin, MT 59034	665-8700	665-3675
3. Blaine	100 Chippewa Street West Harlem, MT 59526	353-4269 353-4271 353-4285	353-4286
4. Broadwater	124 North Cedar Townsend, MT 59644	266-3157	266-3158
5. Carbon	206 North Broadway P.O. Box 670 Red Lodge, MT 59068	446-1302	446-1680
6. Carter	10 West Fallon Ave. P.O. Box 750 Baker, MT 59313	775-8751	
7. Cascade	201 1st Street S., Suite 1 P.O. Box 1546 Great Falls, MT 59401	454-5640	454-5697
8. Chouteau	1020 13th Street P.O. Box 459 Fort Benton, MT 59442	622-5432 or 622-5433	622-3848
9. Custer	1010 Main Street Courthouse Basement Miles City, MT 59301	874-3334	233-3449
10. Daniels	100 West Laurel Ave. Plentywood, MT 59254	765-1370	765-1374
11. Dawson	121 South Douglas Glendive, MT 59330	377-4314 377-6505	377-5917
12. Deer Lodge	307 East Park, Rm. 305 Anaconda, MT 59711	563-3448	563-7279

Local Offices of Public Assistance (continued)

County	Address	Phone Number	Fax Number
13. Fallon	10 West Fallon Ave. P.O. Box 759 Baker, MT 59313	778-7120	778-2815
14. Fergus	300 1st Ave. N., Suite 201 Lewistown, MT 59457	538-7468	538-8419
15. Flathead	2282 Highway 93 South P.O. Box 1096 Kalispell, MT 59903	751-5900 751-5921	751-5929
16. Gallatin	237 West Main Bozeman, MT 59715	582-3010	582-3114
17. Garfield	217 W. Parks P.O. Box 531 Terry, MT 59349	635-2133	635-4110
18. Glacier	**For Browning:** 101 East Main P.O. Box 3025 Browning, MT 59417 **For Cutbank:** 505 East Main Cutbank, MT 59427	**Browning:** 338-5131 338-5162 **Cutbank:** 873-5860	**Browning:** 338-7769 **Cutbank:** 873-5859
19. Golden Valley	201 A Ave. NW Harlowton, MT 59036	(800) 811-8011	632-4880
20. Granite	220 N. Sansomme P.O. Box 370 Phillipsburg, MT 59858	859-0009	859-3817
21. Hill	Courthouse Annex 302 4th Ave. Havre, MT 59501	265-4348	265-6919
22. Jefferson	P.O. Box 836 114 South Washington Boulder, MT 59632	225-4045	225-4023
23. Judith Basin	300 1st Ave. N., Suite 201 Lewistown, MT 59457	566-2499	
24. Lake	826 Shoreline Dr. Polson, MT 59860	883-7820	883-5320
25. Lewis & Clark	P.O. Box 202959 3075 North Montana Ave. Helena, MT 59620-2959	444-1700	444-1751

Local Offices of Public Assistance (continued)

County	Address	Phone Number	Fax Number
26. Liberty	Courthouse 302 4th Ave. Havre, MT 59501	265-4348	265-6919
27. Lincoln	117 Commerce Way Libby, MT 59923	293-3791	293-5549
28. Madison	313 East Idaho P.O. Box 75 Virginia City, MT 59755	843-5324	843-5325
29. McCone	217 W. Parks P.O. Box 531 Terry, MT 59349	635-2133	635-4110
30. Meagher	P.O. Box 514 15 West Main, Courthouse White Sulphur Springs, MT 59645	222-8000 or 547-3752 Ext. 4	547-3388
31. Mineral	305 W. Main St. P.O. Box 626 Superior, MT 59872	822-4551 Ext. 1 or 2	822-3217
32. Missoula	2677 Palmer, Suite 100 Missoula, MT 59808	329-1200	329-1240 329-1270
33. Musselshell	26 Main St. Roundup, MT 59072	323-2101	323-2007
34. Park	220 E. Park Livingston, MT 59047	222-8000	222-5742
35. Petroleum	300 1st Ave. N., Suite 201 Lewistown, MT 59457	566-2277 Ext. 108 566-2499	
36. Phillips	314 2nd Ave. W. P.O. Box 1339 Malta, MT 59538	654-2252	654-2254
37. Pondera	Pondera County CFS 300 N. Virginia St., Ste 320 Conrad, MT 59425-1662	271-4020	271-4074
38. Powder River	217 W. Parks P.O. Box 531 Terry, MT 59349	635-2133	635-4110
39. Powell	409 Missouri Deer Lodge, MT 59722	846-3680 Ext. 214	846-3257

Local Offices of Public Assistance (continued)

County	Address	Phone Number	Fax Number
40. Prairie	P.O. Box 531 Terry, MT 59349	635-2133	635-4110
41. Ravalli	310 N. 3rd Street Hamilton, MT 59840	363-1944	363-2138
42. Richland	221 5th Street SW Sidney, MT 59270	433-2282	433-2015
43. Roosevelt	Courthouse Building 400 2nd Avenue South Wolf Point, MT 59201	653-1210 (866) 653-1210	653-2057
44. Rosebud	121 North 11th Avenue P.O. Box 5016 Forsyth, MT 59327	356-2563	356-7166
45. Sanders	2 Tradewinds Way Thompson Falls, MT 59873	827-4395	827-5395
46. Sheridan	100 West Laurel Ave. Plentywood, MT 59254	765-1370	765-1374
47. Silver Bow	700 Casey Street Butte, MT 59701	496-4900	496-4901
48. Stillwater	P.O. Box 928 43 North 4th Street Columbus, MT 59019	322-5331	322-4076
49. Sweet Grass	5th and Hooper Big Timber, MT 59011	932-5266	932-6628
50. Teton	20 1st St. NW P.O. Box 803 Choteau, MT 59422	466-5721	466-2349
51. Toole	Courthouse 226 1st Street S. Shelby, MT 59474	434-2371	434-7054
52. Treasure	121 North 11th Avenue P.O. Box 5016 Forsyth, MT 59327	365-2563	356-7166

Local Offices of Public Assistance (continued)

County	Address	Phone Number	Fax Number
53. Valley	Courthouse Annex 501 Court Square, Box 9 Glasgow, MT 59230	228-8221 X44	228-4030
54. Wheatland	201 A Avenue NW P.O. Box 4920 Harlowton, MT 59036	800-811-8011	632-4880
55. Wibaux	10 West Fallon Ave. P.O. Box 759 Baker, MT 59313	796-2403 778-7120	778-2815
56. Yellowstone	111 North 31st Street Billings, MT 59101	256-6950	256-6996

MONTANA
Department of Public Health & Human Services

Appendix C: Forms

Medicaid Form Order

Copy and complete this form, and mail to the address below or fax to (406) 442-4402. Please allow three to four weeks for delivery. These forms (and others) are also available on the Provider Information website (see *Key Contacts*) and in most Medicaid billing manuals for your provider type. To obtain CMS-1500, UB92, or universal pharmacy claim forms, contact a printing and publishing company. To obtain ADA dental forms, call (800) 947-4746.

Montana Medicaid
P.O. Box 8000
Helena, MT 59604

Montana Medicaid **Date** _____

MEDICAID FORM ORDER

Form Name	Quantity	Form Name	Quantity
Pharmacy (MA-5)		Hysterectomy Form	
Nursing Home (MA-3)		Sterilization Consent Form	
Dental P.A. Request (MA-4PA)		Eligibility Inquiry Form (SRS-456)	
Adjustment Form		Abortion Certification (MA-037)	
Claim Inquiry Form			

Provider Information
Provider Number: _____
Name: _____
Street Address: _____
City: _____ State: _____ Zip: _____

Return Form To:
Montana Medicaid
P.O. Box 8000
Helena, MT 59604

P O Box 4936
Helena, MT 59604
Telephone: (406) 422-1837 Local and Out-of-State
In-State Toll Free: 1-800-624-3958
Fax: (406) 422-4402

Address Correction Form

Provider Name _____

Provider Number _____

Provider Phone Number _____

Physical Address _____

_____

_____

Pay to Address _____

_____

_____

Correspondence Address _____

_____

_____

Authorized Signature _____ Date _____

Sample Presumptive Eligibility Notice of Decision

DPHHS-HCS-428
(Rev. 2/02

State of Montana
Department of Public Health and Human Services
Human and Community Services Division

Presumptive Eligibility Notice of Decision

TO:	FROM:
Jane Doe 123 A Street Anytown, MT 59999	Department of Public Health and Human Services

Social Security Number 555-55-5555
Date of Birth 10-02-82
Estimated Date of Delivery 05-29-02
County of Residence Lewis and Clark

QPEP: **Please complete entire form prior to faxing to:**

444-7358

(DPHHS Help Desk)

Your application for Presumptive Eligibility has been:

[X] approved effective 09-03-01. You are eligible for payment of prenatal care. This does not include hospitalization or delivery. ***Take this form with you each time you seek medical care.***

Your Presumptive Eligibility continues until whichever happens first:

1. the day a determination of ineligibility is made for Medicaid; or
2. 10-31-01 (last day of month following month of approved effective date.)

Your medical provider will check your eligibility status at the time of your appointment.

[ ] denied because _____

_____

The application form you submitted will be sent to _____ so it can be evaluated for Medicaid and other public assistance programs. Please contact that office to ensure all information necessary to determine your Medicaid eligibility has been provided to them.

Nancy N. Nelson — *Signature of Qualified Presumptive Eligibility Provider*

09-31-01 — *Date*

NOTICE TO MEDICAID PROVIDERS:

1. **You must call 1-800-93C-HILD (1-800-932-4453)** to confirm eligibility ***before providing a service*** or you may not get paid.
2. Make a copy of this document for your own records. Please ***return*** the original document to the client.
3. Submit all your claims for processing to:
   ACS
   PO Box 8000
   Helena, MT 59604
4. If you have questions regarding claims processing, please call: *Provider Relations, ACS (406) 442-1837 or 442-1838. Instate Watts 1-800-624-3958.*

DISTRIBUTION: ***One Copy - Client*** ***One Copy - OPA*** ***One Copy - QPEP***

Sample Medicaid Incurment Notice

SRS-FA-454
(Rev. 12/92)

STATE OF MONTANA
Department of Public Health and Human Services
MEDICAID PROGRAM

Provider Informational Memo

Medicaid Incurment

Provider: Medical Center
123 Main
Anytown, MT 59999

Provider ID: 1234567

Recipient: Jane Doe

Birthdate: 10/02/82 ID#: 555-55-5555

Recipient Responsibility: The recipient is responsible for $ 82.39 of the charge for the service(s) provided on 03/10/01

The balance of the charge will be paid up to the Medicaid rate.

Eligibility Period: The recipient will be Medicaid eligible from 03/11/01 to 03/31/01

Prepared by: Mary Johnson Date: 06/05/01

County: Lewis and Clark

Distribution: One copy - Client One copy - Case File

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Administrative Review
Administrative reviews are the Department's effort to resolve a grievance about a Department decision in order to avoid a hearing. The review includes an informal conference with the Department to review facts, legal authority, and circumstances involved in the adverse action by the Department.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Ancillary Provider
Any provider that is subordinate to the client's primary provider, or providing services in the facility or institution that has accepted the client as a Medicaid client.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Patients with Basic Medicaid have limited Medicaid services. See *Appendix A: Medicaid Covered Services.*

Cash Option
Cash option allows the client to pay a monthly premium to Medicaid and have Medicaid coverage for the entire month rather than making payments to providers.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid program. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
CHIP offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured US citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program and purchases health insurance from BlueCross BlueShield (BCBS) of Montana. Benefits for dental services and eyeglasses are provided by DPHHS through the same contractor (ACS) that handles Medicaid provider relations and claims processing.

Children's Special Health Services (CSHS)
CSHS provides assistance for children with special health care needs. CSHS assists in paying for medical expenses related to specific conditions, specialty clinics, and finding resources. Medicaid eligible children do not receive assistance with medical expenses from CSHS, but specialty clinics are open to all children with special health care needs. CSHS is funded by Title V, the Maternal and Child Health Block Grant.

Clean Claim
A claim that can be processed without additional information or documentation from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicare (usually a percentage). Medicare coinsurance is usually 20% of the Medicare allowed amount.

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost sharing
The client's financial responsibility for a medical bill, usually in the form of a flat fee.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Dual Eligibles
Clients who are covered by Medicare and Medicaid are often referred to as "dual eligibles."

Early and Periodic Screening Diagnosis and Treatment (EPSDT)
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Emergency Medical Services
Emergency medical services are those services required to treat and stabilize an emergency medical condition.

Experimental
A non-covered item or service that researchers are studying to investigate how it affects health.

Fair Hearing
Providers may request a fair hearing when the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules or policies. Fair hearings include a hearings officer, attorneys, and witnesses for both parties.

Fiscal Agent
ACS is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.86 et seq.

Full Medicaid
Patients with Full Medicaid have a full scope of Medicaid benefits. See *Appendix A: Medicaid Covered Services*.

Indian Health Services (IHS)
IHS provides federal health services to American Indians and Alaska Natives.

Investigational
A non-covered item or service that researchers are studying to investigate how it affects health.

Kiosk
A "room" or area in the Montana Virtual Human Services Pavilion (VHSP) web site that contains information on the topic specified.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medicaid Eligibility and Payment System (MEPS)
A computer system by which providers may access a client's eligibility, demographic, and claim status history information via the internet.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Montana Breast and Cervical Cancer Treatment Program
This program provides Basic Medicaid coverage for women who have been screened through the Montana Breast and Cervical Health Program (MBCHP) and diagnosed with breast and/or cervical cancer or a pre-cancerous condition.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Private-pay
When a client chooses to pay for medical services out of his or her own pocket.

Protocols
Written plans developed by a public health clinic in collaboration with physician and nursing staff. Protocols specify nursing procedures to be followed in giving a specific exam, or providing care for particular conditions. Protocols must by updated and approved by a physician at least annually.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the department.

Qualified Medicare Beneficiary (QMB)
QMB clients are clients for whom Medicaid pays their Medicare premiums and some or all of their Medicare coinsurance and deductibles.

Remittance Advice (RA)
The results of processed claims (including paid, denied, and pending claims) are listed on the RA.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Routine Podiatric Care
Routine podiatric care includes the cutting or removing of corns and calluses, the trimming of nails or the application of skin creams and other hygiencic, preventive maintenance care and debridement of nails.

Sanction
The penalty for noncompliance with laws, rules, and policies regarding Medicaid. A sanction may include withholding payment from a provider or terminating Medicaid enrollment.

Specified Low-Income Medicare Beneficiaries (SLMB)
For these clients, Medicaid pays the Medicare premium only. They are not eligible for other Medicaid benefits, and must pay their own Medicare coinsurance and deductibles.

Spending Down
Clients with high medical expenses relative to their income can become eligible for Medicaid by "spending down" their income to specified levels. The client is responsible to pay for services received before eligibility begins, and Medicaid pays for remaining covered services.

Team Care
A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)
Any entity that is, or may be, liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Timely Filing
Providers must submit clean claims (claims that can be processed without additional information or documentation from or action by the provider) to Medicaid within the latest of

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- 6 months from the date on the Medicare explanation of benefits approving the service
- 6 months from the date on an adjustment notice from a third party payor who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

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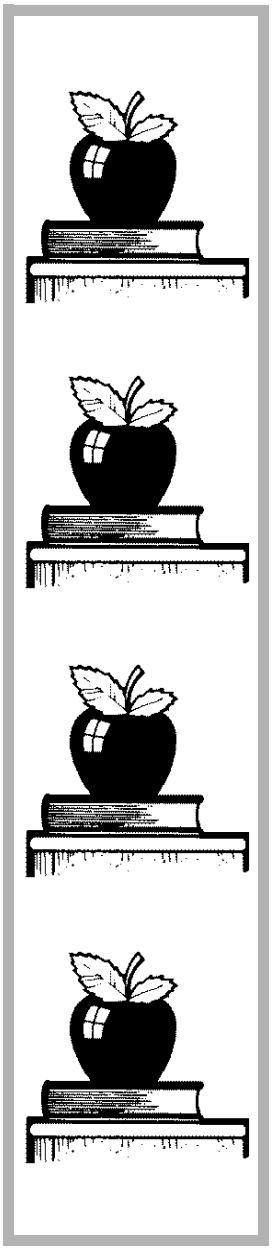

General Information For Providers II

Medicaid and Other Medical Assistance Programs

The topics covered in this manual will eventually be included in the Medicaid billing manual for your provider type.

MONTANA
Department of Public Health & Human Services

September, 2004

This publication supersedes previous general information provider handbooks. This publication is to be used with the General Information For Providers manual (dated February, 2002) and with the specific provider manual(s). General Information For Providers II was published by the Department of Public Health & Human Services February, 2002.

Updated September, 2002, October 2003, September 2004.

This manual is for providers whose Medicaid billing manual for their provider type does not have chapters titled *Coordination of Benefits, Billing Procedures,* and *Remittance Advices and Adjustments*.

MONTANA
Department of Public Health & Human Services

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Key Contacts

Hours for Key Contacts are 8:00 a.m. to 5:00 p.m. Monday through Friday (Mountain Time), unless otherwise stated. The phone numbers designated "In state" will not work outside Montana.

Provider Relations

Contact Provider Relations for questions about Medicaid, MHSP, and CHIP eyeglass and dental questions including payments, denials, eligibility, general claims questions, and PASSPORT or Medicaid questions or enrollment:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena
(406) 442-4402 Fax

Send written inquiries to:

Provider Relations Unit
P.O. Box 4936
Helena, MT 59604

Claims

Send paper claims to:

Claims Processing Unit
P. O. Box 8000
Helena, MT 59604

Third Party Liability

For questions about private insurance, Medicare or other third-party liability:

(800) 624-3958 In state
(406) 442-1837 Out of state and Helena

Send written inquiries to:

ACS Third Party Liability Unit
P. O. Box 5838
Helena, MT 59604

Client Eligibility

For client eligibility, see the *General Information For Providers* manual, *Client Eligibility and Responsibilities* chapter.

Medicaid Client Help Line

Clients who have general Medicaid questions or PASSPORT questions may call the Montana Medicaid Help Line:

(800) 362-8312

Send written inquiries to:

PASSPORT To Health
P.O. Box 254
Helena, MT 59624-0254

Provider's Policy Questions

For policy questions, contact the appropriate division of the Department of Public Health and Human Services; see the *General Information For Providers* manual, *Introduction.*

ACS EDI Gateway

For questions regarding electronic claims submissions:

(800) 987-6719 Phone
(850) 385-1705 Fax

ACS EDI Gateway Services
P.O. Box 4936
Helena, MT 59604

Technical Services Center

Providers who would like to receive their remittance advices electronically and electronic funds transfer should call the number below and ask for the Medicaid Direct Deposit Manager.

(406) 444-9500

Team Care Program Officer

For questions regarding the Team Care Program:

(406) 444-4540 Phone
(406) 444-1861 Fax

Team Care Program Officer
DPHHS
Managed Care Bureau
P.O. Box 202951
Helena, MT 59620-2951

Prior Authorization

The following are some of the Department's prior authorization contractors. Providers should refer to their specific provider manual for specific prior authorization instructions.

Surveillance/Utilization Review

For prior authorization for cosmetic services and Durable Medical Equipment (DME), contact the SURS unit at:

(406) 444-0190 Phone
(406) 444-3993 Phone
(406) 444-0778 Fax

Send written inquiries to:

2401 Colonial Drive
P.O. Box 202953
Helena, MT 59620-2953

First Health

For questions regarding prior authorization and continued stay review for selected mental health services.

First Health Services
4300 Cox Road
Glen Allne, VA 23060

(800) 770-3084 Phone
(800) 639-8982 Fax

Mountain Pacific Quality Health Foundation

For questions regarding drug prior authorization:

Phone:
(800) 395-7961 In state
(406) 443-6002 Out of state and Helena

Fax:
(800) 294-1350 In state
(406) 443-7014 Out of state and Helena

Send written inquiries to:

Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

For questions regarding ambulance and commercial transportation prior authorization:

Phone:
(406) 443-6100 Helena
(800) 292-7114 In and out of state

Fax:
(406) 443-0684 Helena
(800) 291-7791 In and out of state

Send written inquiries to:

MPQHF
Medicaid Transportation Center
P.O. Box 6488
Helena, MT 59604-6488

For questions regarding prior authorization for out-of-state hospital services, emergency department reviews, transplant services, and private duty nursing services, call:

Phone:
(800) 262-1545 X5850 In and out of state
(406) 443-4020 X5850 Helena

Fax:
(800) 497-8235 In and out of state
(406) 443-4585 Out of state and Helena

Send written inquiries to:
Mountain-Pacific Quality
Health Foundation
3404 Cooney Drive
Helena, MT 59602

Key Web Sites

Web Address	Information Available
Virtual Human Services Pavilion (VHSP) vhsp.dphhs.mt.gov	**Select *Human Services* for the following information:** • **Medicaid:** Medicaid Eligibility & Payment System (MEPS). Eligibility and claims history information and a link to the Provider Information Website. • **Senior and Long Term Care:** Provider search, home/housing options, healthy living, government programs, publications, protective/legal services, financial planning. • **DPHHS:** Latest news and events, DPHHS information, services available, and legal information.
Provider Information Website www.mtmedicaid.org or www.dphhs.mt.gov/hpsd/medicaid/medicaid2/index.htm	• Medicaid news • Provider manuals • Notices and manual replacement pages • Fee schedules • Remittance advice notices • PASSPORT To Health information • Forms • Provider enrollment • Frequently asked questions (FAQs) • Upcoming events • HIPAA Update • Newsletters • Key contacts • Links to other websites and more
CHIP Website www.chip.mt.gov	• Information on the Children's Health Insurance Plan (CHIP)
ACS EDI Gateway www.acs-gcro.com/Medicaid_Account/Montana/montana.htm	ACS EDI Gateway is Montana's HIPAA clearinghouse. Visit this website for more information on: • Provider Services • EDI Support • Enrollment • Manuals • Software • Companion Guides • FAQs • Related Links (see link to Implementation Guides)
Washington Publishing Company www.wpc-edi.com	• EDI implementation guides • HIPAA implementation guides • EDI education • HIPAA tools

Coordination of Benefits

When Clients Have Other Coverage

Medicaid clients often have coverage through Medicare, workers' compensation, employment-based coverage, individually purchased coverage, etc. Coordination of benefits is the process of determining which source of coverage is the primary payer in a particular situation. In general, providers should bill other carriers before billing Medicaid, but there are some exceptions (see *Exceptions to Billing Third Party First* in this chapter). Medicare is processed differently than other sources of coverage.

Identifying Additional Coverage

The client's Medicaid eligibility verification may identify other payers such as Medicare or other third party payers (see the *General Information For Providers* manual, *Client Eligibility and Responsibilities*). If a client has Medicare, the Medicare ID number is provided. If a client has additional coverage, the carrier is shown. Some examples of third party payers include:

- Private health insurance
- Employment-related health insurance
- Workers' Compensation Insurance*
- Health insurance from an absent parent
- Automobile insurance*
- Court judgments and settlements*
- Long term care insurance

*These third party payers (and others) may **not** be listed on the client's eligibility verification.

Providers should use the same procedures for locating third party sources for Medicaid clients as for their non-Medicaid clients. Providers cannot refuse service because of a third party payer or potential third party payer.

When a Client Has Medicare

Medicare claims are processed and paid differently than other non-Medicaid claims. The other sources of coverage are called third party liability or TPL, but Medicare is not.

Medicare Part A claims

To date, arrangements have not been made with Medicare Part A carriers for electronic exchange of institutional claims covering Part A services. Providers must submit these claims first to Medicare. After Medicare processes the claim, an Explanation of Medicare Benefits (EOMB) is sent to the provider. The provider then reviews the EOMB and submits the claim to Medicaid.

To avoid confusion and paperwork, submit Medicare Part B crossover claims to Medicaid only when necessary.

Medicare Part B crossover claims

The Department has an agreement with the Medicare Part B carriers for Montana (BlueCross BlueShield of Montana and the Durable Medical Equipment Regional Carrier [DMERC]) under which the carriers provide the Department with a magnetic tape of CMS-1500 claims for clients who have both Medicare and Medicaid coverage. Providers must tell Medicare that they want their claims sent to Medicaid automatically, and must have their Medicare provider number on file with Medicaid.

When clients have both Medicare and Medicaid covered claims, and have made arrangements with both Medicare and Medicaid, Part B services need not be submitted to Medicaid. When a crossover claim is submitted only to Medicare, Medicare will process the claim, submit it to Medicaid, and send the provider an Explanation of Medicare Benefits (EOMB). Providers must check the EOMB for the statement indicating that the claim has been referred to Medicaid for further processing. It is the provider's responsibility to follow up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

Providers should submit Medicare crossover claims to Medicaid only when:

- The referral to Medicaid statement is missing. In this case, submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- The referral to Medicaid statement is present, but you do not hear from Medicaid within 45 days of receiving the Medicare EOMB. Submit a claim and a copy of the Medicare EOMB to Medicaid for processing.
- Medicare denies the claim, you may submit the claim to Medicaid with the EOMB and denial explanation (as long as the claim has not automatically crossed over from Medicare).

When submitting electronic claims with paper attachments, see the *Billing Electronically with Paper Attachments* section of the *Billing Procedures* chapter.

All Part B Crossover claims submitted to Medicaid before Medicare's 45-day response time will be returned to the provider.

When submitting a claim with the Medicare EOMB, use Medicaid billing instructions and codes. Medicare's instructions, codes, and modifiers may not be the same as Medicaid's. The claim must also include the Medicaid provider number and Medicaid client ID number. It is the provider's responsibility to follow-up on crossover claims and make sure they are correctly billed to Medicaid within the timely filing limit (see the *Billing Procedures* chapter in this manual).

When a Client Has TPL (ARM 37.85.407)

When a Medicaid client has additional medical coverage (other than Medicare), it is often referred to as third party liability or TPL. In most cases, providers must bill other insurance carriers before billing Medicaid.

Providers are required to notify their clients that any funds the client receives from third party payers (when the services were billed to Medicaid) must be turned over to the Department. The following words printed on the client's statement will fulfill this obligation, "When services are covered by Medicaid and another source, any payment the client receives from the other source must be turned over to Medicaid."

Exceptions to Billing Third Party First

In a few cases, providers may bill Medicaid first:

- When a Medicaid client is also covered by Indian Health Services (IHS) or Crime Victim's Compensation, providers must bill Medicaid first. These are not considered a third party liability.
- When a client has Medicaid eligibility and MHSP eligibility for the same month, Medicaid must be billed first.
- Some prenatal and pediatric codes can be billed directly to Medicaid. In these cases, Medicaid will "pay and chase" or recover payment itself from the third party payer.

Codes That May be Billed to Medicaid First

ICD-9-CM Prenatal Codes	ICD-9-CM Preventive Pediatric Codes
V22.0	V01.0 – V01.9
V22.1	V02.0 – V02.9
V23.0 – V23.9	V03.0 – V06.9
V28.0 – V28.9	V07.0 – V07.9
640.0 – 648.9*	V20.0 – V20.2
651.0 – 658.9*	V70.0
671.0 – 671.9	V72.0 – V72.3
673.0 – 673.8	V73.0 – V75.9
675.0 – 676.9	V77.0 – V77.7
	V78.1 – V78.3
	V79.2 – V79.3
	V79.8
	V82.3 – V82.4

* In these two ranges, the code only qualifies for the exemption if the fifth digit is a 3 (e.g. 648.93).

- The following services may also be billed to Medicaid first:
  - Nursing facility (as billed on nursing home claims)
  - Audiology
  - Hearing aids and batteries
  - Eyeglasses
  - Drugs (as billed on drug claims)
  - Personal assistance
  - Transportation (other than ambulance)
  - Optometry
  - Oxygen in a nursing facility
  - Dental and denturist (as billed on dental claims)
  - Home and Community Based Services (waiver)
- If the third party has only potential liability, such as automobile insurance, the provider may bill Medicaid first. Do not indicate the potential third party on the claim. Instead, notify the Department of the potential third party by sending the claim and notification directly to the Department Third Party Liability Unit:

  Third Party Liability Unit
  Department of Public Health & Human Services
  P.O. Box 202953
  Helena, MT 59620-2953

Requesting an Exemption

Providers may request to bill Medicaid first under certain circumstances. In each of these cases, the claim and required information should be sent directly to the ACS Third Party Liability Unit (see *Key Contacts*).

- When a provider is unable to obtain a valid assignment of benefits, the provider should submit the claim with documentation that the provider attempted to obtain assignment and certification that the attempt was unsuccessful.
- When the provider has billed the third party insurance and has received a non-specific denial (e.g., no client name, date of service, amount billed), submit the claim with a copy of the denial and a letter of explanation.
- When the child support enforcement division has required an absent parent to have insurance on a child, the claim can be submitted to Medicaid when the following requirements are met:
  - The third party carrier has been billed, and 30 days or more have passed since the date of service.
  - The claim is accompanied by a certification that the claim was billed to the third party carrier, and payment or denial has not been received.

- If another insurance has been billed, and 90 days have passed with no response, submit the claim with a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company). Include the date the claim was submitted to the insurance company and certification that there has been no response.

If the provider receives a payment from a third party after the Department has paid the provider, the provider must return the lower of the two payments to the Department within 60 days.

When the Third Party Pays or Denies a Service

When a third party payer is involved (excluding Medicare) and the other payer:

- Pays the claim, indicate the amount paid when submitting the claim to Medicaid for processing.
- Allows the claim, and the allowed amount went toward client's deductible, include the insurance Explanation of Benefits (EOB) when billing Medicaid.
- Denies the claim, submit the claim and a copy of the denial (including the reason explanation) to Medicaid.
- Denies a line on the claim, bill the denied line on a separate claim and submit to Medicaid. Include the explanation of benefits (EOB) from the other payer as well as an explanation of the reason for denial (e.g., definition of denial codes).

When the Third Party Does Not Respond

If another insurance has been billed, and 90 days have passed with no response, bill Medicaid as follows:

- Submit the claim and a note explaining that the insurance company has been billed (or a copy of the letter sent to the insurance company).
- Include the date the claim was submitted to the insurance company.
- Send this information to the ACS Third Party Liability Unit (see *Key Contacts*).

Other Programs

The information covered in this chapter also applies to clients enrolled in the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) dental services and eyeglasses only.

Billing Procedures

Timely Filing Limits (ARM 37.85.406)

Providers must submit clean claims to Medicaid within the latest of:

- 12 months from whichever is later:
  - the date of service
  - the date retroactive eligibility or disability is determined
- For claims involving Medicare or TPL, if the twelve month time limit has passed, providers must submit clean claims to Medicaid within:
  - ***Medicare crossover claims:*** Six months from the date on the Medicare explanation of benefits approving the service (if the Medicare claim was timely filed and the client was eligible for Medicare at the time the Medicare claim was filed).
  - ***Claims involving other third party payers (excluding Medicare):*** Six months from the date on an adjustment notice from a third party payer who has previously processed the claim for the same service, and the adjustment notice is dated after the periods described above.

Clean claims are claims that can be processed without additional information or documentation from or action by the provider. The submission date is defined as the date the claim was received by the Department or the claims processing contractor. All errors and problems with claims must be resolved within this 12 month period.

Tips to Avoid Timely Filing Denials

- Correct and resubmit denied claims promptly (see the *Remittance Advices and Adjustments* chapter in this manual).
- If a claim submitted to Medicaid does not appear on the remittance advice within 45 days, contact Provider Relations for claim status (see *Key Contacts*).
- If another insurer has been billed and 90 days have passed with no response, you can bill Medicaid (see the *Coordination of Benefits* chapter in this manual for more information).
- To meet timely filing requirements for Medicare/Medicaid crossover claims, see the *Coordination of Benefits* chapter in this manual.

Billing for Retroactively Eligible Clients

When a client becomes retroactively eligible for Medicaid, the provider has 12 months from the date retroactive eligibility was determined to bill for those services. When submitting claims for retroactively eligible clients, submit a copy of the HCS-455 (Eligibility determination letter) when the date of service is outside the 12 month limit.

When a provider chooses to accept the client from the date retroactive eligibility was effective, and the client has made a full or partial payment for services, the provider must refund the client's payment for the service(s) before billing Medicaid for the service(s).

When Clients Have Other Insurance

If a Medicaid client is also covered by Medicare, has other insurance, or some other third party is responsible for the cost of the client's health care, see *Coordination of Benefits.*

Billing for Emergency Services

The Department covers emergency services provided in the emergency department. Emergency medical services are those services required to treat and stabilize an emergency medical condition. A service is reimbursed as an emergency if one of the following criteria is met:

- The service is billed with a CPT code of 99284 or 99285
- The client has a qualifying emergency diagnosis code. A list of the Department's pre-approved emergency diagnosis codes is available on the Provider Information website (see *Key Contacts*).
- The service did not meet one of the previous two requirements, but the medical professional rendering the medical screening and evaluation believes an emergency existed. In this case, the claim and documentation supporting the emergent nature of the services must be mailed to the emergency department review contractor (see *Key Contacts*).

If the visit does not meet one of the emergency criteria, then services beyond the screening and related diagnostic tests are not reimbursed and cost sharing should be collected. If the visit meets the emergency criteria, cost sharing is not collectible.

If an inpatient hospitalization is recommended as post stabilization treatment, the hospital must get a referral from the client's PASSPORT provider (See the *PASSPORT and Prior Authorization* chapter in the *General Information For Providers* manual).

When Can I Bill a Medicaid Client Directly? (ARM 37.85.406)

In most circumstances, providers may not bill clients for services covered under Medicaid. The main exception is that providers should bill clients for cost sharing.

More specifically, providers cannot bill clients directly:

- For the difference between charges and the amount Medicaid paid.
- For a covered service provided to a Medicaid-enrolled client who was accepted as a medicaid client, even if the claim was denied.
- When a third-party payer does not respond.
- When a client fails to arrive for a scheduled appointment without cancelling or rescheduling in advance. Medicaid may not be billed for no-show appointments either.
- When the provider bills Medicaid for a covered service, and Medicaid denies the claim because of billing errors.
- When services are being provided free to the client, such as in a public health clinic. Medicaid may not be billed for those services either.

If a provider bills Medicaid and the claim is denied because the client is not eligible, the provider may bill the client directly.

Providers may bill Medicaid clients directly under the following circumstances:

- For cost sharing. Providers may choose to collect client cost sharing at the time of service or bill the client later.
- For services not covered by Medicaid, as long as the provider and client have agreed in writing prior to providing services.
    - When the provider does not accept the client as a Medicaid client, it is sufficient for the provider to use a routine agreement to inform the client that he or she is not accepted as a Medicaid client, and that the client agrees to be financially responsible for the services received.
    - When the client has been accepted as a Medicaid client, but the services are not covered by Medicaid, the services can be billed to the client only after the provider has informed the client in writing (before providing the service) that those services are not covered by Medicaid, and the client has agreed to pay for the specific services on a private-pay basis. In this case, a routine agreement will not suffice. (ARM 37.85.406) For more information on billing Medicaid clients, see *Billing Procedures* in the specific provider manual.

Under certain circumstances, providers may need a signed agreement in order to bill a Medicaid client (see the following table).

When to Bill a Medicaid Client (ARM 37.85.406)

	• Client Is Medicaid Enrolled • Provider Accepts Client as a Medicaid Client	• Client Is Medicaid Enrolled • Provider Does Not Accept Client as a Medicaid Client	• Client Is Not Medicaid Enrolled
Service is covered by Medicaid	Provider can bill client **only** for cost sharing	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client
Service is not covered by Medicaid	Provider can bill client only if custom agreement has been made between client and provider before providing the service	Provider can bill Medicaid client if the client has signed a routine agreement	Provider can bill client

Routine Agreement: This may be a routine agreement between the provider and client which states that the client is not accepted as a Medicaid client, and that he or she must pay for the services received.

Custom Agreement: This agreement lists the service and date the client is receiving the service and states that the service is not covered by Medicaid and that the client will pay for it.

Coding

Standard use of medical coding conventions is required when billing Medicaid. The most current edition of the following manuals should be used:

- ICD-9-CM
- CPT-4
- HCPCS Level II
- CDT-4
- Montana UB-92 Reference Manual

Always refer to the long descriptions in coding books.

Provider Relations or the Department cannot suggest specific codes to be used in billing for services. The following suggestions may help reduce coding errors:

- Use current CPT-4, HCPCS Level II, ICD-9-CM, and CDT-4 coding books, and refer to the long descriptions. Relying on short descriptions can result in inappropriate billing.
- Use the current Montana UB-92 Reference manual from the Montana Hospital Association (MHA). It contains current revenue codes.

- Attend classes on coding offered by certified coding specialists.
- Use specific codes rather than miscellaneous codes. For example, 99213 is more specific (problem-focused visit) rather than 99499 (unlisted evaluation and management service).
- Bill for the appropriate level of service provided. For example, the CPT-4 coding book contains detailed descriptions and examples of what differentiates a level 1 office visit (99201) from a level 5 office visit (99205).
- Services covered within "global periods" for certain CPT-4 procedures are not paid separately and should not be billed separately. Most surgical and obstetric procedures and some medical procedures include routine care before and after the procedure. Medicaid fee schedules show the global period for each CPT-4 service.
- Pay close attention to modifiers used with CPT-4 and HCPCS codes on both CMS-1500 bills and UB-92 bills. Modifiers are becoming more prevalent in health care billing, and they often affect payment calculations.
- Use the correct "units" measurement on CMS-1500 and UB-92 bills. In general, Medicaid follows the definitions in the CPT-4 and HCPCS billing manuals. Unless otherwise specified, one unit equals one visit or one procedure. For specific codes, however, one unit may be 15 minutes, a percentage of body surface area, or another quantity. Always check the long text of the code description.

Coding Resources

Please note that the Department does not endorse the products of any particular publisher.

Resource	Description	Contact
ICD-9-CM	• ICD-9-CM diagnosis and procedure codes definitions • Updated each October.	Available through various publishers and bookstores
CPT-4	• CPT-4 codes and definitions • Updated each January	American Medical Association (800) 621-8335 www.amapress.com or Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
HCPCS Level II	• HCPCS Level II codes and definitions • Updated each January and throughout the year	Available through various publishers and bookstores or from CMS at www.cms.gov
CPT Assistant	A newsletter on CPT-4 coding issues	American Medical Association (800) 621-8335 www.amapress.com
Miscellaneous resources	Various newsletters and other coding resources.	Medicode (Ingenix) (800) 765-6588 www.medicode.com or www.ingenixonline.com
CCI Policy and Edits Manual	This manual contains Correct Coding Initiative (CCI) policy and edits, which are pairs of CPT-4 or HCPCS Level II codes that are not separately payable except under certain circumstances. The edits are applied to services billed by the same provider for the same client on the same date of service.	National Technical Information Service (800) 363-2068 (703) 605-6060 www.ntis.gov/product/correct-coding.htm
UB-92 National Uniform Billing Data Element Specifications	Montana UB-92 billing instructions	MHA - An Association of Montana Health Care Providers (formerly Montana Hospital Assoc.) Box 5119 Helena, MT 59604 406-442-1911 phone 406-443-3984 fax
CDT-4 Dental Terminology Manual	Dental terminology	American Dental Association Council on Dental Care Programs 211 East Chicago Avenue Chicago, IL 60611-2678 800- 947-4746 7:00 a.m. to 5:00 p.m. (Central time)

Client Cost Sharing (ARM 37.85.204 and 37.85.402)

Cost sharing fees are a set dollar amount per visit, and they are based on the average Medicaid allowed amount for the provider type and rounded to the nearest dollar. There is no cost sharing cap, except for prescription drug services (see following table). Do not show cost sharing as a credit on the claim; it is automatically deducted and shown on the remittance advice.

A provider cannot deny services to a Medicaid client due to the client's inability to pay cost sharing at the time services are rendered. However, the client's inability to pay cost sharing at the time services are rendered does not lessen the client's obligation to pay cost sharing. If a provider has a policy on collecting delinquent payment from non-Medicaid clients, that same policy may be used for Medicaid clients whose cost sharing is delinquent.

Cost Sharing

Provider Type	Amount
Ambulatory surgical center	$5.00 per visit
Audiology	$2.00 per visit
Dental	$3.00 per visit
Denturist	$5.00 per visit
Dialysis clinic (freestanding)	$5.00 per visit
Durable medical equipment and medical supplies and prosthetic devices	$5.00 per visit
FQHC	$5.00 per visit
Hearing aid services	$2.00 per visit
Home health (not including durable medical equipment and medical supplies)	$3.00 per visit
Home infusion therapy services	$5.00 per visit
Hospital (inpatient)	$100 per discharge
Hospital (outpatient)	$5.00 per visit
Independent diagnostic testing facility services	$4.00 per visit
Licensed social worker	$3.00 per visit
Licensed professional counselor	$3.00 per visit
Licensed psychiatrist	$4.00 per visit
Licensed psychologist	$3.00 per visit
Mid-level practitioner	$4.00 per visit
Occupational therapy	$2.00 per visit
Optometric and optician	$2.00 per visit
Physical therapy (outpatient)	$2.00 per visit
Physician	$4.00 per visit
Podiatry	$4.00 per visit
Prescription drugs (outpatient) $1.00 minimum	$1.00 - $5.00 per script, with a $25.00 monthly cap
Public health clinic	$1.00 per visit
RHC	$5.00 per visit
Speech therapy	$3.00 per visit

The following clients are exempt from cost sharing:

- Individuals under 21 years of age
- Pregnant women (until end of postpartum, which begins on the last day of pregnancy and ends at the end of the month in which 60 days have passed)
- Inpatients in a hospital, skilled nursing facility, intermediate care facility or other medical institution if the individual is required to spend all but their personal needs allowance on the cost of care.
- Medicaid clients who also have Medicare or another insurance are exempt from cost sharing only when the service is allowed by Medicare or paid by the other insurance, and Medicaid is the secondary payer.

Cost sharing may not be charged for the following services:

- Emergencies (see *Emergency Services* earlier in this chapter)
- Family planning
- Hospice
- Independent lab and x-ray services
- Personal assistance services
- Home dialysis attendant services
- Home and community based waiver services
- Non-emergency medical transportation services
- Eyeglasses purchased by the Medicaid program under a volume purchasing arrangement
- EPSDT services

Submitting a Claim

Paper claims

Unless otherwise stated, all paper claims should be mailed to:

Claims Processing
P.O. Box 8000
Helena, MT 59604

All Medicaid claims must be submitted on Department approved claim forms. Many Medicaid-related forms are available in the specific provider manuals; others are available the Provider Information website (see *Key Contacts*). To order additional forms, see the *Medicaid Form Order* sheet in the *General Information For Providers* manual, *Appendix C*: *Forms*. For instructions on completing claim forms, refer to your specific provider manual. The following are approved forms:

- CMS-1500 (formerly HCFA-1500) *

- UB-92 *
- ADA Dental claim form *
- MA-3 Nursing home form
- MA-5 Pharmacy claim form

*Medicaid does not provide these forms.

Submitting electronic claims

Professional, institutional, and dental claims submitted electronically are referred to as ANSI ASC X12N 837 transactions. Providers who submit claims electronically experience fewer errors and quicker payment. Providers who are using any of the following electronic claims submission methods, must enroll with the ACS EDI Gateway clearinghouse (see *Key Contacts*). Claims may be submitted electronically by the following methods:

- ACS field software WINASAP 2003. ACS makes available this free software, which providers can use to create and submit claims to Montana Medicaid, MHSP, and CHIP (dental and eyeglasses only). It does not support submissions to Medicare or other payers. This software creates an X12N 837 transaction, but does not accept an X12N 835 (electronic RA) transaction back from the Department.
- ACS clearinghouse. Providers can send claims to the ACS clearinghouse (ACS EDI Gateway) in X12N 837 format using a dial-up connection. Electronic submitters are required to certify their X12N 837 transactions as HIPAA-compliant before sending their transactions through the ACS clearinghouse. EDIFECS certifies the X12N 837 HIPAA transactions at no cost to the provider. EDIFECS certification is completed through ACS EDI Gateway.
- Clearinghouse. Providers can contract with a clearinghouse so that the provider can send the claim to the clearinghouse in whatever format the clearinghouse accepts. The provider's clearinghouse then sends the claim to the ACS clearinghouse in the X12N 837 format. The provider's clearinghouse also needs to have their X12N 837 transactions certified through EDIFECS before submitting claims to the ACS clearinghouse. EDIFECS certification is completed through ACS EDI Gateway

For more information on electronic claims submission, contact Provider Relations or ACS EDI Gateway. Companion Guides for electronic transactions are available on the ACS EDI Gateway website. Implementation Guides are available from the Washington Publishing website (see *Key Contacts*).

The number in the *Attachment Control Number* field must match the number on the cover sheet.

Billing Electronically with Paper Attachments

When submitting claims that require additional supporting documentation, the *Attachment Control Number* field must be populated with an identifier. Identifier formats can be designed by software vendors or clearinghouses, but the preferred method is the provider's Medicaid ID number followed by the client's ID number and the date of service, each separated by a dash:

9999999	-	**888888888**	-	**11182003**
Medicaid Provider ID		Client ID Number		Date of Service (mmddyyyy)

The supporting documentation must be submitted with a paperwork attachment cover sheet (located on the Provider Information website and in *Appendix A: Forms*). The number in the paper *Attachment Control Number* field must match the number on the cover sheet. For more information on attachment control numbers and submitting electronic claims, see the Companion Guides located on the ACS EDI website (see *Key Contacts*).

Claim Inquiries

Claim inquiries can be obtained electronically through ANSI ASC X12N 276/277 transactions or by contacting Provider Relations. See the Companion Guides located on the ACS EDI Gateway website for more information on electronic transactions (see *Key Contacts*). Providers may contact Provider Relations for questions regarding payments, denials, and other claim questions (see *Key Contacts*).

If you prefer to communicate with Provider Relations in writing, use the *Montana Medicaid Claim Inquiry* form in *Appendix A.* Complete the top portion of the form with the provider's name and address.

Provider Relations will respond to the inquiry within 7 to 10 days. The response includes the status of the claim: paid (date paid), denied (date denied), or in process. Denied claims will include an explanation of the denial and steps to follow for payment (if the claim is payable).

The Most Common Billing Errors and How to Avoid Them

Paper claims are often returned to the provider before they can be processed, and many others are denied. To avoid returns and denials, double check each claim form to confirm the following items are included and accurate.

Common Billing Errors

Reasons for Return	How to Prevent Returned Claims
Medicaid provider number missing or invalid	The provider number is a 7-digit number assigned to the provider during Medicaid enrollment. Verify the correct **Medicaid** provider number is on the billing form.
Authorized signature missing	Each claim form must have an authorized signature belonging to the provider, billing clerks, or office personnel. The signature may be typed, stamped, computer generated, or hand-written.
Signature date missing	Each form must have a signature date.
Incorrect claim form used	The claim form must be the correct form for the provider type. Refer to the Medicaid billing manual for your provider type.
Information on claim form not legible	Information on the claim form should be legible. Use dark ink and center the information in the field – information should not be obscured by lines.
NABP number missing (pharmacy claims only)	Pharmacies must use their NABP number for billing Medicaid. Verify the correct number is included on the form.
Recipient number not on file, or recipient was not eligible on date of service	Before providing services to the client: • Verify client eligibility by using one of the methods described in the *General Information For Providers* manual, *Client Eligibility and Responsibilities* chapter.
Duplicate claim	• Please check all remittance advices for previously submitted claims before resubmitting. • When making changes to previously paid claims, submit an adjustment form rather than a new claim form (see *Remittance Advices and Adjustments*). • Please allow 45 days for the Medicare/Medicaid Part B crossover claim to appear on the RA before submitting the claim directly to Medicaid.
Prescription refill too soon (pharmacy claims only)	Prescription refills will be denied if refilled too soon. See the *Prescription Drug Program* manual for instructions on requesting early refills.
Procedure requires PASSPORT provider approval – No PASSPORT approval number on claim	A PASSPORT provider approval number must be on the claim form when such approval is required. See *Prior Authorization and PASSPORT.*
Dispense as Written (DAW) code missing or invalid (Pharmacy claims only)	Refer to the *Prescription Drug Program* manual for instructions on using DAW codes.

Common Billing Errors (continued)

Reasons for Return	How to Prevent Returned Claims
Prior authorization number is missing	• Prior authorization (PA) is required for certain services, and the PA number must be on the claim form. Refer to your specific provider manual. • MHSP claims must be billed and services performed during the prior authorization span. The claim will be denied if it is not billed according to the spans on the authorization. See your specific provider manual.
TPL on file and no credit amount on claim	• If the client has any other insurance (or Medicare), bill the other carrier before Medicaid. See *Coordination of Benefits.* • If the client's TPL coverage has changed, providers must notify the TPL unit (see *Key Contacts*) before submitting a claim.
Drug Utilization Review (DUR) reject error (Pharmacy claims only)	Refer to the Prescription Drug Program manual for information.
Claim past 365-day filing limit	• The Claims Processing Unit must receive all clean claims and adjustments within the timely filing limits described in the *Billing Procedures* chapter. • To ensure timely processing, paper claims and adjustments should be mailed to Claims Processing at the address shown in *Key Contacts*.
Missing Medicare EOMB	All Medicare crossover claims on CMS-1500 forms must have an EOMB attached.
Invalid type of bill (UB-92s only)	The bill type should be a 3-digit number, please refer to the UB-92 billing manual for details.
Provider is not eligible during dates of services, or provider number terminated	• Out-of-state providers must update enrollment early to avoid denials. If enrollment has lapsed, claims submitted with a date of service after the expiration date will be denied. • New providers cannot bill for services provided before Medicaid enrollment begins. • If a provider requests to be terminated from the Medicaid program, claims submitted with a date of service after the termination date will be denied.
Type of service/procedure is not allowed for provider type	• Provider is not allowed to perform the service, or type of service is invalid. • Verify the procedure code is correct using current HCPCS and CPT-4 billing manual. • Check the Medicaid fee schedule to verify the procedure code is valid for your provider type.
Invalid or discontinued NDC code (pharmacy claims only)	Verify whether the NDC code has been discontinued or changed (Provider Relations may be able to determine if the code is invalid or discontinued).

Other Programs

These billing procedures are the same for Medicaid and the Mental Health Services Plan (MHSP). These billing procedures also apply to Children's Health Insurance Plan (CHIP) dental services and eyeglasses only. For CHIP claims and other information see the *General Information For Providers* manual, *Program Policy Information.*

MONTANA
Department of Public Health & Human Services

Remittance Advices and Adjustments

The Remittance Advice

The Remittance Advice (RA) is the best tool providers have to determine the status of a claim. RAs accompany payment for services rendered. The RA provides details of all transactions that have occurred during the previous RA cycle. Providers may select a one or two week payment cycle (see *Payment and the RA* in this chapter). Each line of the RA represents all or part of a claim, and explains whether the claim or service has been paid, denied, or suspended (also referred to as pending). If the claim was suspended or denied, the RA also shows the reason.

Electronic RA

Providers may receive the RA electronically as an ANSI ASC X12N 835 transaction, or through the Internet on the Montana Eligibility and Payment System (MEPS). For more information on X12N 835 transactions, see the Companion Guides available on the ACS EDI Gateway website and the Implementation Guides on the Washington Publishing Company website (see *Key Contacts*).

MEPS is available through the Virtual Human Services Pavilion (see *Key Contacts*). In order to access MEPS, you must complete an *Access Request Form* see *Payment and the RA* within this chapter). After this form has been processed, you will receive a password. Entry into the system requires a valid provider or group number and password. Each provider or group number requires a unique password, so providers must complete a separate request form for each provider or group.

RAs are available from MEPS in PDF and a flat file format. You can read, print, or download PDF files using Adobe Acrobat Reader, which is available on the "SOR Download" page. The file layout for flat files is also available on the SOR download page. Due to space limitations, each RA is only available for six weeks. For more information on MEPS, see *Payment and the RA* later in this chapter.

Paper RA

The paper RA is divided into the following sections: RA notice, paid claims, denied claims, pending claims, credit balance claims, gross adjustments, and reason and remark codes and descriptions. See the following sample paper RA and the *Keys to the Paper RA* table.

Electronic RAs are available for only six weeks on MEPS.

If a claim was denied, read the reason and remark code description before taking any action on the claim.

The pending claims section of the paper RA is informational only. Do not take any action on claims shown here.

Sections of the Paper RA

Section	Description
RA notice	The RA Notice is on the first page of the remittance advice. This section contains important messages about rate changes, revised billing procedures, and many other items that may affect providers and claims.
Paid claims	This section shows claims paid during the previous cycle. It is the provider's responsibility to verify that claims were paid correctly. If Medicaid overpays a claim and the problem is not corrected, it may result in an audit and the provider having to return the overpayment plus interest. If a claim was paid at the wrong amount or with incorrect information, the claim must be adjusted (see *Adjustments* later in this chapter).
Denied claims	This section shows claims denied during the previous cycle. If a claim has been denied, refer to the Reason/Remark column (Field 16). The reason and remark code description explains why the claim was denied and is located at the end of the RA. See *The Most Common Billing Errors and How to Avoid Them* in the *Billing Procedures* chapter.
Pending claims	All claims that have not reached final disposition will appear in this area of the paper RA (pended claims are not available on X12N 835 transactions). The RA uses "suspended" and "pending" interchangeably. They both mean that the claim has not reached final disposition. If a claim is pending, refer to the Reason/Remark Code column (Field 16). The reason and remark code description located at the end of the RA will explain why the claim is suspended. This section is informational only. Please do not take any action on claims displayed here. Processing will continue until each claim is paid or denied. Claims shown as pending with reason code 133 require additional review before a decision to pay or deny is made. If a claim is being held while waiting for client eligibility information, it may be suspended for a maximum of 30 days. If Medicaid receives eligibility information within the 30-day period, the claim will continue processing. If no eligibility information is received within 30 days, the claim will be denied. When a claim is denied for lack of eligibility, the provider should verify that the correct Medicaid ID number was billed. If the ID number was incorrect, resubmit the claim with the correct ID number.
Credit balance claims	Credit balance claims are shown here until the credit has been satisfied.
Gross adjustments	Any gross adjustments performed during the previous cycle are shown here.
Reason and remark code description	This section lists the reason and remark codes that appear throughout the RA with a brief description of each.

Sample Paper Remittance Advice

DEPARTMENT OF PUBLIC HEALTH & HUMAN SERVICES
HELENA, MT 59604

MEDICAID REMITTANCE ADVICE

(1)

JOHN R. SMITH MD
2100 NORTH MAIN STREET
WESTERN CITY MT 59988

(2) PROVIDER# 0001234567 (3) REMIT ADVICE #123456 (4) WARRANT # 123456 (5) DATE:04/01/01 PAGE 2 (6)

RECIP ID (7)	NAME (8)	SERVICE DATES FROM	TO (10)	UNIT OF SVC (11)	PROCEDURE REVENUE NDC (12)	TOTAL CHARGES (13)	ALLOWED (14)	CO-PAY (15)	REASON/ REMARK CODES (16)
PAID CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	010501	011501	1	99213	35.00	23.39	Y	
(9) ICN	00200112500000700								
		LESS COPAY DEDUCTION***					1.00 (17)		
		CLAIM TOTAL*******				35.00	22.39		
DENIED CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	010501	011501	1	99213	35.00	0.00	N	31MA61
ICN	00200112500000800	ADDITIONAL EOB: 047 (16)							
		010501	011501	2	99214	25.00	12.35	N	
PENDING CLAIMS - MISCELLANEOUS CLAIMS									
123456789	DOE, JOHN EDWARD	010501	011501	1	99213	35.00	0.00	N	31
ICN	00200112500000900	010501	011501	2	99214	25.00	12.35	N	31

**********THE FOLLOWING IS A DESCRIPTION OF THE REASON/REMARK CODES THAT APEAR ABOVE**********

31 CLAIM DENIED AS PATIENT CANNOT BE IDENTIFIED AS OUR INSURED.

MA61 DID NOT COMPLETE OR ENTER CORRECTLY THE PATIENT'S SOCIAL SECURITY NUMBER OR HEALTH INSURANCE CLAIM NUMBER.

Key to the Paper RA

Field	Description
1. Provider name and address	Provider's business name and address as recorded with the Department
2. Provider number	The 7-digit number assigned to the provider when applying for Medicaid
3. Remittance advice number	The remittance advice number
4. Warrant number	Not used
5. Date	The date the RA was issued
6. Page Number	The page number of the RA
7. Recipient ID	The client's Medicaid ID number
8. Name	The client's name
9. Internal control number (ICN)	Each claim is assigned a unique 17-digit number (ICN). Use this number when you have any questions concerning your claim. The claim number represents the following information: 0 00111 11 123 000123 A B C D E A = Claim medium 0 = Paper claim 2 = Electronic claim 3 = Encounter claim 4 = System generated claim (mass adjustment, nursing home turn-around document, or POS pharmacy claim) B = Julian date (e.g. April 20, 2000 was the 111th day of 2000) C = Microfilm number 00 = Electronic claim 11 = Paper claim D = Batch number E = Claim number If the first number is: 0 = Regular claim 1 = Negative side adjustment claim (Medicaid recovers payment) 2 = Positive side adjustment claim (Medicaid reprocesses)
10. Service dates	Date(s) services were provided. If service(s) were performed in a single day; the same date will appear in both columns
11. Unit of service	The number of services rendered under this procedure or NDC code.
12. Procedure/revenue/NDC	The procedure, revenue, HCPCS, or NDC billed will appear in this column. If a modifier was used, it will also appear in this column.
13. Total charges	The amount a provider billed for this service.
14. Allowed	The Medicaid allowed amount.
15. Co-pay	A "Y" indicates cost sharing was deducted, and an "N" indicates cost sharing was not deducted from the payment.
16. Reason/Remark Code	A code which explains why the specific service was denied or pended. Descriptions of these codes are listed at the end of the RA.
17. Deductions, Billed Amount, and Paid Amount	Any deductions, such as cost sharing or third party liability are listed first. The amount the provider billed is next, followed by the amount of Medicaid reimbursement.

Credit balance claims

Credit balances occur when claim adjustments reduce original payments causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the RA until the credit has been satisfied.

Credit balances can be resolved in two ways:

- By "working off" the credit balance. Remaining credit balances can be deducted from future claims. These claims will continue to appear on consecutive RAs until the credit has been paid.
- By sending a check payable to DPHHS for the amount owed. This method is required for providers who no longer submit claims to Montana Medicaid. Please attach a note stating that the check is to pay off a credit balance and include your provider number. Send the check to the attention of the *Provider Relations Field Representative* at the Provider Relations address in *Key Contacts*.

The Credit Balance section is informational only. Do not post from credit balance statements.

Rebilling and Adjustments

Rebillings and adjustments are important steps in correcting any billing problems you may experience. Knowing when to use the rebilling process versus the adjustment process is important.

How long do I have to rebill or adjust a claim?

- Providers may resubmit, modify, or adjust any initial claim within the timely filing limits described in the *Billing* chapter.
- The time periods do not apply to overpayments that the provider must refund to the Department. After the 12 month time period, a provider may not refund overpayments to the Department by completing a claim adjustment. The provider may refund overpayments by issuing a check, or request Provider Relations to complete a gross adjustment.

Medicaid does not accept any claim for resubmission, or adjustment after 12 months from the date of service (see *Timely Filing Limits* in the *Billing Procedures* chapter.)

Rebilling Medicaid

Rebilling is when a provider submits a claim to Medicaid that was previously submitted for payment but was either returned or denied. Claims are often returned to the provider before processing because key information such as Medicaid provider number or authorized signature and date are missing or unreadable. For tips on preventing returned or denied claims, see the *Billing Procedures* chapter in this manual.

When to rebill Medicaid

- ***Claim Denied.*** Providers may rebill Medicaid when a claim is denied. Check the reason and remark codes, make the appropriate corrections and resubmit the claim (do not use the adjustment form).

Rebill denied claims only after appropriate corrections have been made.

- ***Line Denied.*** When an individual line is denied on a multiple-line claim, correct any errors and rebill Medicaid. For CMS-1500 claims, do not use an adjustment form. In the case of a UB-92, the line should be adjusted rather than rebilled (see *Adjustments*).
- ***Claim Returned.*** Rebill Medicaid when the claim is returned under separate cover. Occasionally, Medicaid is unable to process the claim and will return it to the provider with a letter stating that additional information is needed to process the claim. Correct the information as directed and resubmit the claim.

How to rebill

- Check any reason and remark code listed and make corrections on a copy of the claim, or produce a new claim with the correct information.
- When making corrections on a copy of the claim, remember to line out or omit all lines that have already been paid.
- Submit insurance information with the corrected claim.

Adjustments

If a provider believes that a claim has been paid incorrectly, the provider may call Provider Relations (see *Key Contacts*) or submit a claim inquiry for review (see *Billing Procedures, Claim Inquiry*). Once an incorrect payment has been verified, the provider should submit an *Individual Adjustment Request* form (in *Appendix A*), to Provider Relations. If incorrect payment was the result of an ACS keying error, contact Provider Relations.

When adjustments are made to previously paid claims, the Department recovers the original payment and issues appropriate repayment. The result of the adjustment appears on the provider's RA as two transactions. The original payment will appear as a credit transaction. The replacement claim reflecting the corrections will be listed as a separate transaction and may or may not appear on the same RA as the credit transaction. The replacement transaction will have nearly the same ICN number as the credit transaction, except the 12th digit over will be a 2, indicating an adjustment. See the *Key to the Paper RA* earlier in this chapter. Adjustments are processed in the same time frame as claims.

When to request an adjustment

- Request an adjustment when the claim was overpaid or underpaid.
- Request an adjustment when the claim was paid but the information on the claim was incorrect (such as client ID, provider number, date of service, procedure code, diagnoses, units, etc.).

- Request an adjustment when an individual line is denied on a multiple-line UB-92 claim. The denied service must be submitted as an adjustment rather than a rebill.

How to request an adjustment

To request an adjustment, use the *Montana Medicaid Individual Adjustment Request* form in *Appendix A*. The requirements for adjusting a claim are as follows:

- Adjustments can only be submitted on paid claims; denied claims cannot be adjusted.
- Claims Processing must receive individual claim adjustments within 12 months from the date of service (see *Timely Filing* in the *Billing Procedures* chapter of this manual). After this time, *gross adjustments* are required (see *Definitions*).
- Use a separate adjustment request form for each ICN.
- If you are correcting more than one error per ICN, use only one adjustment request form, and include each error on the form.
- If more than one line of the claim needs to be adjusted, indicate which lines and items need to be adjusted in the *Remarks* section.

Completing an Adjustment Request Form

1. Copy the *Montana Medicaid Individual Adjustment Request* form from *Appendix A*, or download it from the Provider Information website. Complete *Section A* first with provider and client information and the claim's ICN number (see following table).
2. Complete *Section B* with information about the claim. Remember to fill in only the items that need to be corrected (see following table):
    - Enter the date of service or the line number in the *Date of Service or Line Number* column.
    - Enter the information from the claim form that was incorrect in the *Information on Statement* column.
    - Enter the correct information in the column labeled *Corrected Information*.
3. Attach copies of the RA and a corrected claim if necessary.
    - If the original claim was billed electronically, a copy of the RA will suffice.
    - If the RA is electronic, attach a screen print of the RA.
4. Verify the adjustment request has been signed and dated.
5. Send the adjustment request to Claims Processing (see *Key Contacts*).

Completing an Individual Adjustment Request Form

Field	Description
Section A	
1. Provider Name and Address	Provider's name and address (and mailing address if different).
2. Recipient Name	The client's name is here.
3.* Internal Control Number (ICN)	There can be only one ICN per Adjustment Request form. When adjusting a claim that has been previously adjusted, use the ICN of the most recent claim.
4.* Provider number	The provider's Medicaid ID number.
5.* Recipient Medicaid Number	Client's Medicaid ID number.
6. Date of Payment	Date claim was paid found on Remittance Advice Field #5 (see the sample RA earlier in this chapter).
7. Amount of Payment	The amount of payment from the Remittance Advice Field #17 (see the sample RA earlier in this chapter.).
Section B	
1. Units of Service	If a payment error was caused by an incorrect number of units, complete this line.
2. Procedure Code/ N.D.C/ Revenue Code	If the procedure code, NDC, or revenue code are incorrect, complete this line.
3. Dates of Service (D.O.S)	If the date(s) of service is incorrect, complete this line.
4. Billed Amount	If the billed amount is incorrect, complete this line.
5. Personal Resource (Nursing Home)	If the client's personal resource amount is incorrect, complete this line.
6. Insurance Credit Amount	If the client's insurance credit amount is incorrect, complete this line.
7. Net (Billed – TPL or Medicare Paid)	If the payment error was caused by a missing or incorrect insurance credit, complete this line. Net is billed amount minus the amount TPL or Medicare paid.
8. Other/Remarks	If none of the above items apply, or if you are unsure what caused the payment error, complete this line.

* Indicates a required field

- If an original payment was an underpayment by Medicaid, the adjustment will result in the provider receiving the additional payment amount allowed.
- If an original payment was an overpayment by Medicaid, the adjustment will result in recovery of the overpaid amount from the provider. This can be done in two ways, by the provider issuing a check to the Department, or by maintaining a credit balance until it has been satisfied with future claims (see *Credit Balance* earlier in this chapter).
- Any questions regarding claims or adjustments should be directed to Provider Relations (see *Key Contacts*).

Mass adjustments

Mass adjustments are done when it is necessary to reprocess multiple claims. They generally occur when:

- Medicaid has a change of policy or fees that is retroactive. In this case federal laws require claims affected by the changes to be mass adjusted.
- A system error that affected claims processing is identified.

Providers are informed of mass adjustments on the first page of the remittance advice (RA Notice section), the monthly Claim Jumper, or provider notice. Mass adjustment claims shown on the RA have an ICN that begins with a "4" (see *Key Fields on the Remittance Advice* earlier in this chapter).

Payment and The RA

Weekly payments are available only to providers who receive both EFT **and** electronic RAs.

Providers may receive their Medicaid payment and remittance advice either weekly or biweekly. Payment can be via check or electronic funds transfer (EFT). Direct deposit is another name for EFT. Providers who wish to receive weekly payment must request both EFT and electronic RAs and specifically request weekly payment. For biweekly payment, providers can choose any combination of paper/electronic payment method and RA.

With EFT, the Department deposits the funds directly to the provider's bank account. If the scheduled deposit day is a holiday, funds will be available on the next business day. This process does not affect the delivery of the remittance advice that providers currently receive with payments. RAs will continue to be mailed to providers unless they specifically request an electronic RA.

To participate in EFT, providers must complete a *Direct Deposit Sign-Up Form* (Standard Form 1199A) (see the following table). One form must be completed for each provider number.

Once electronic transfer testing shows payment to the provider's account, all Medicaid payments will be made through EFT. For questions or changes regarding EFT, contact the Technical Services Center and ask for the Medicaid Direct Deposit Manager (see *Key Contacts*).

Required Forms For EFT and/or Electronic RA

All three forms are required for a provider to receive weekly payment

Form	Purpose	Where to Get	Where to Send
Electronic Remittance Advice and Payment Cycle Enrollment Form	Allows provider to receive electronic remittance advices on MEPS (must also include MEPS Access Request form)	• Provider Information website • Provider Relations (see *Key Contacts*)	Provider Relations (see *Key Contacts*)
Direct Deposit Sign-up Form Standard Form 1199A	Allows the Department to automatically deposit Medicaid payment into provider's bank account	• Provider Information website (see *Key Contacts*) • Provider's bank	Provider Relations (see *Key Contacts*)
MEPS Access Request Form	Allows provider to receive a password to access their RA on MEPS	• Provider Information website • Virtual Human Services Pavilion • Direct Deposit Manager of the DPHHS Technical Services Center (see *Key Contacts)*	DPHHS address on the form

Other Programs

The information in this chapter also applies to the Mental Health Services Plan (MHSP) and the Children's Health Insurance Plan (CHIP) dental and eyeglasses benefits.

Appendix A:
Forms

Montana Medicaid Claim Inquiry Form

Montana Medicaid Individual Adjustment Request Form

Paperwork Attachment Cover Sheet

Montana Medicaid Claim Inquiry Form

Provider Name _____
Contact Person _____
Address _____
Date _____
Phone Number _____
Fax Number _____

For status on a claim, please complete the information on this form and mail to the address below or fax to the number shown. You may attach a copy of the claim, but it is not required.

Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____
Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____
Provider number _____	ACS Response: _____
Client number _____	_____
Date of service _____	_____
Total billed amount _____	_____
Date submitted for processing _____	_____
	_____

Mail to: Provider Relations
P.O. Box 8000
Helena, MT 59604

Fax to: (406) 442-4402

MONTANA MEDICAID/MHSP/CHIP
INDIVIDUAL ADJUSTMENT REQUEST

INSTRUCTIONS:

This form is for providers to correct a claim which has been paid at an incorrect amount or was paid with incorrect information. Complete all the fields in Section A with information about the paid claim from your statement. Complete ONLY the items in Section B which represent the incorrect information that needs changing. For help with this form, refer to the *Remittance Advices and Adjustments* chapter in your program manual or the *General Information For Providers II* manual, or call (800) 624-3958 (Montana Providers) or (406) 442-1837 (Helena and out-of-state providers).

A. COMPLETE ALL FIELDS USING THE PAYMENT STATEMENT (R.A.) FOR INFORMATION

1. PROVIDER NAME & ADDRESS

_____
Name

_____
Street or P.O. Box

_____
City **State** **Zip**

2. CLIENT NAME

_____

3. INTERNAL CONTROL NUMBER (ICN)

_____

4. PROVIDER NUMBER

_____

5. CLIENT ID NUMBER

_____

6. DATE OF PAYMENT _____

7. AMOUNT OF PAYMENT $ _____

B. COMPLETE ONLY THE ITEM(S) WHICH NEED TO BE CORRECTED

	DATE OF SERVICE OR LINE NUMBER	INFORMATION STATEMENT	CORRECTED INFORMATION
1. Units of Service			
2 Procedure Code/N.D.C./Revenue Code			
3. Dates of Service (D.O.S.)			
4. Billed Amount			
5. Personal Resource (Nursing Home)			
6. Insurance Credit Amount			
7. Net (Billed - TPL or Medicare Paid)			
8. Other/REMARKS (BE SPECIFIC)			

SIGNATURE: _____ **DATE:** _____

When the form is complete, attach a copy of the payment statement (RA) and a copy of the corrected claim (unless you bill EMC).

MAIL TO: Provider Relations
ACS
P.O. Box 8000
Helena, MT 59604

MONTANA
Department of Public Health & Human Services

Paperwork Attachment Cover Sheet

Paperwork Attachment Control Number: _____

Date of service: _____

Medicaid provider number: _____

Medicaid client ID number: _____

Type of attachment: _____

Instructions:

This form is used as a cover sheet for attachments to electronic claims sent to Montana Medicaid. The *Paperwork Attachment Control Number* must be the same number as the *Attachment Control Number* on the corresponding electronic claim. This number should consist of the provider's Medicaid ID number, the client's Medicaid ID number and the date of service (mmddyyyy), each separated by a dash (9999999-999999999-99999999). This form may be copied or downloaded from our website www.mtmedicaid.org. If you have questions about which paper attachments are necessary for a claim to process, please call Provider Relations at (406) 442-1837 or (800) 624-3958.

Definitions and Acronyms

This section contains definitions, abbreviations, and acronyms used in this manual.

270/271 Transactions
The ASC X12N eligibility inquiry (270) and response (271) transactions.

276/277 Transactions
The ASC X12N claim status request (276) and response (277) transactions.

278 Transactions
The ASC X12N request for services review and response used for prior authorization.

835 Transactions
The ASC X12N payment and remittance advice (explanation of benefits) transaction.

837 Transactions
The ASC X12N professional, institutional, and dental claim transactions (each with its own separate Implementation Guide).

Accredited Standards Committee X12, Insurance Subcommittee (ASC X12N)
The ANSI-accredited standards development organization, and one of the six Designated Standards Maintenance Organizations (DSMO), that has created and is tasked to maintain the administrative and financial transactions standards adopted under HIPAA for all health plans, clearinghouses, and providers who use electronic transactions.

Adjustment
When a claim has been incorrectly paid, the payment amount can be changed by submitting an adjustment request.

Administrative Review
Administrative reviews are the Department's effort to resolve a grievance about a Department decision in order to avoid a hearing. The review includes an informal conference with the Department to review facts, legal authority, and circumstances involved in the adverse action by the Department.

Administrative Rules of Montana (ARM)
The rules published by the executive departments and agencies of the state government.

Assignment of Benefits
When a provider accepts the maximum allowable charge offered for a given procedure by the insurance company, it is said that the provider accepts assignment.

Audit
A formal or periodic verification of accounts.

Authorization
An official approval for action taken for, or on behalf of, a Medicaid client. This approval is only valid if the client is eligible on the date of service.

Basic Medicaid
Clients with Basic Medicaid have limited Medicaid services. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services*.

Carrier
A private insurance company.

Centers for Medicare and Medicaid Services (CMS)
Administers the Medicare program and oversees the state Medicaid program. Formerly the Health Care Financing Administration (HCFA).

Children's Health Insurance Plan (CHIP)
CHIP offers low-cost or free health insurance for low-income children younger than 19. Children must be uninsured US citizens or qualified aliens, Montana residents who are not eligible for Medicaid. DPHHS administers the program and purchases health insurance from BlueCross BlueShield (BCBS) of Montana. Benefits for dental services and eyeglasses are provided by DPHHS through the same contractor (ACS) that handles Medicaid provider relations and claims processing.

Children's Special Health Services (CSHS)
CSHS provides assistance for children with special health care needs. CSHS assists in paying for medical expenses related to specific conditions, specialty clinics, and finding resources. Medicaid eligible children do not receive assistance with medical expenses from CSHS, but specialty clinics are open to all children with special health care needs. CSHS is funded by Title V, the Maternal and Child Health Block Grant.

Claims Attachment
Supplemental information about the services provided to a client that supports medical or other evaluation for payment, post-payment review, or quality control requirements that are directly related to one or more specific services billed on the claim.

Claims Clearinghouse
When a provider contracts with a clearinghouse, the clearinghouse supplies the provider with software that electronically transmits claims to the clearinghouse. The clearinghouse then transmits the claims to the appropriate payers.

Clean Claim
A claim that can be processed without additional information or documentation from or action by the provider of the service.

Client
An individual enrolled in a Department medical assistance program.

Coinsurance
The client's financial responsibility for a medical bill as assigned by Medicare. Medicare coinsurance is usually 20% of the Medicare allowed amount.

Companion Guide
A document provided by some health plans to supplement or clarify information about HIPAA standard transactions (available on the ACS EDI Gateway website).

Copayment
The client's financial responsibility for a medical bill as assigned by Medicaid (usually a flat fee).

Cosmetic
Serving to modify or improve the appearance of a physical feature, defect, or irregularity.

Cost sharing
The client's financial responsibility for a medical bill, usually in the form of a flat fee.

CPT-4
Physicians' ***Current Procedural Terminology, Fourth Edition***. This book contains procedure codes which are used by medical practitioners in billing for services rendered. The book is published by the American Medical Association.

Credit Balance Claims
Adjusted claims that reduce original payments, causing the provider to owe money to the Department. These claims are considered in process and continue to appear on the remittance advice until the credit has been satisfied.

Crossovers
Claims for clients who have both Medicare and Medicaid. These claims may come electronically from Medicare or directly from the provider.

DPHHS, State Agency
The Montana Department of Public Health and Human Services (DPHHS or Department) is the designated State Agency that administers the Medicaid program. The Department's legal authority is contained in Title 53, Chapter 6 MCA. At the Federal level, the legal basis for the program is contained in Title XIX of the Social Security Act and Title 42 of the Code of Federal Regulations (CFR). The program is administered in accordance with the Administrative Rules of Montana (ARM), Title 37, Chapter 86.

Early & Periodic Screening, Diagnosis & Treatment (EPSDT) Program
This program provides Medicaid-covered children with comprehensive health screenings, diagnostic services, and treatment of health problems.

Electronic Data Interchange (EDI)
The communication of information in a stream of data from one party's computer system to another party's computer system.

Electronic Funds Transfer (EFT)
Payment of medical claims that are deposited directly to the provider's bank account.

Emergency Services
Those services which are required to evaluate and stabilize a medical condition manifesting itself by acute symptoms of sufficient severity (including pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or unborn child) in serious jeopardy, serious impairment to bodily function or serious dysfunction of any bodily organ or part.

Explanation of Benefits Codes (EOB)
A three digit code which prints on Medicaid remittance advice (RA) that explains why a claim was denied or suspended. The explanation of the EOB codes is found at the end of the RA.

Explanation of Medicare Benefits (EOMB)
A notice sent to providers informing them of the services which have been paid by Medicare.

Fair Hearing
Providers may request a fair hearing when the provider believes the Department's administrative review determination fails to comply with applicable laws, regulations, rules or policies. Fair hearings include a hearings officer, attorneys, and witnesses for both parties.

Fiscal Agent
ACS is the fiscal agent for the State of Montana and processes claims at the Department's direction and in accordance with ARM 37.85 et seq.

Full Medicaid
Clients with Full Medicaid have a full scope of Medicaid benefits. See the *General Information For Providers* manual, *Appendix A: Medicaid Covered Services.*

Gross Adjustment
These adjustments are done in a lump-sum payment or reduction without regard to individual claims.

HCPCS
Acronym for the Healthcare Common Procedure Coding System, and is pronounced "hick-picks." There are three types of HCPCS codes:

- Level 1 includes the CPT-4 codes.
- Level 2 includes the alphanumeric codes A - V which CMS maintains for a wide range of services from ambulance trips to hearing aids which are not addressed by CPT-4 coding.
- Level 3 includes the alphanumeric codes W - Z which are assigned for use by state agencies (also known as local codes).

Health Insurance Portability and Accountability Act (HIPAA)
A federal plan designed to improve efficiency of the health care system by establishing standards for transmission, storage, and handling of data.

ICD-9-CM
The International Classification of Diseases, 9th Revision, Clinical Modification. This is a three volume set of books which contains the diagnosis codes used in coding claims, as well as the procedure codes used in billing for services performed in a hospital setting.

Implementation Guide (IG)
The official source of specifications with respect to how the HIPAA administrative and financial transactions are to be implemented (available on the Washington Publishing Company website).

Indian Health Services (IHS)
IHS provides federal health services to American Indians and Alaska Natives.

Internal Control Number (ICN)
The unique number assigned to each claim transaction that is used for tracking.

Mass Adjustment
Adjustments made to multiple claims at the same time. They generally occur when the Department has a change of policy or fees that is retroactive, or when a system error that affected claims processing is identified.

Medicaid
A program that provides health care coverage to specific populations, especially low-income families with children, pregnant women, disabled people and the elderly. Medicaid is administered by state governments under broad federal guidelines.

Medically Necessary
A term describing a requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client. These conditions must be classified as one of the following: endanger life, cause suffering or pain, result in an illness or infirmity, threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There must be no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this definition, "course of treatment" may include mere observation or, when appropriate, no treatment at all.

Medicare
The federal health insurance program for certain aged or disabled clients.

Mental Health Services Plan (MHSP)
This plan is for individuals who have a serious emotional disturbance (SED) or a severe and disabling mental illness (SDMI), are ineligible for Medicaid, and have a family income that does not exceed an amount established by the Department.

Newsletter
An informational letter sent to providers (such as the *Montana Medicaid Claim Jumper* or the *PASSPORT to Health Provider Newsletter*).

PASSPORT Authorization Number
This number is either the PASSPORT provider's PASSPORT number or Medicaid provider ID. When a PASSPORT provider refers a client to another provider for services, this number is given to the other provider and is required when processing the claim.

PASSPORT To Health
A Medicaid managed care program where the client selects a primary care provider who manages the client's health care needs.

Pay and Chase
Medicaid pays a claim and then recovers payment from the third party carrier that is financially responsible for all or part of the claim.

Pending Claim
These claims have been entered into the system, but have not reached final disposition. They require either additional review or are waiting for client eligibility information.

Potential Third Party Liability
Any entity that may be liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Prior Authorization (PA)
The approval process required before certain services or supplies are paid by Medicaid. Prior authorization must be obtained before providing the service or supply.

Provider or Provider of Service
An institution, agency, or person:

- Having a signed agreement with the Department to furnish medical care and goods and/or services to clients; and
- Eligible to receive payment from the Department.

Rebilling
When a provider submits a claim that was previously submitted for payment but was either returned or denied.

Referral
When providers refer clients to other Medicaid providers for medically necessary services that they cannot provide.

Remittance Advice (RA)
Provides details of all transactions that have occurred during the previous two weeks, includes paid, denied, and pending claims.

Remittance Advice Notice
The first page of the remittance advice that contains important messages for providers.

Retroactive Eligibility
When a client is determined to be eligible for Medicaid effective prior to the current date.

Team Care
A utilization control program designed to educate clients on how to effectively use the Medicaid system. Team Care clients are managed by a "team" consisting of a PASSPORT PCP, one pharmacy, the Nurse First Advice Line, and Montana Medicaid.

Third Party Liability (TPL)
Any entity that is liable to pay all or part of the medical cost of care for a Medicaid, MHSP or CHIP client.

Usual and Customary
The fee that the provider most frequently charges the general public for a service or item.

Virtual Human Services Pavilion (VHSP)
This internet site contains a wealth of information about Human Services, Justice, Commerce, Labor & Industry, Education, voter registration, the Governor's Office, and Montana. http://vhsp.dphhs.state.mt.us

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